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The Shape of Things to Come

At the beginning of an unpredictable year a review of the nursing journals in Britain and in the United States of America discloses important trends which merit close attention in Canada. In the United States, the work of the Nursing Council on National Defence continues to go forward with plans for a national nursing inventory, extension of nursing school programs, and preparation for the expansion of nursing services in hospitals and public health agencies. A large increase in the Army Nurse Corps is anticipated, and the Nursing Service of the American Red Cross has undertaken an active program of recruitment.

In the December issue of *The American Journal of Nursing*, Isabel M. Stewart presents a masterly analysis of nursing education in relation to the American National Defence program and it is suggested that the following measures should be included among the immediate objectives :

1. Emergency nursing and first-aid courses for all nurses in active service.

2. "General brushing-up" courses for those out of practice who have had good basic preparation.

3. Retraining for those whose preparation is out of date or inadequate.

4. Specialized training to fit nurses for work in special fields of nursing, such as industrial nursing or the teaching of non-professional groups.

5. "Up-grading" programs for those who are being pushed into higher level positions without adequate preparation.

These measures are eminently practical, and would work out to good advantage even if no military emergency were to arise in the United States. Their most outstanding merit is that they are directed toward increasing the efficiency of fully trained nurses who are already

available for service, rather than toward hurried and therefore inadequate preparation of additional student nurses. It is foreseen that nurses now holding key positions in hospitals and schools of nursing will soon be transferred to institutions more directly connected with national defence. Miss Stewart suggests that younger and less experienced nurses should be prepared forthwith to fill these responsible positions, thus avoiding disruption of service.

American nurses are fortunate in having time to look to their defences before the storm is upon them. In Britain the practice of nursing is now being carried on literally under fire. Under such circumstances, there is neither time nor opportunity for making surveys or for long range planning. All that can be done is to prepare for and meet successive emergencies as they arise. Furthermore, there is no longer a sharp line of demarcation between civilian and military nursing. More than a hundred children, who were victims of the Coventry air raid, had to be admitted to a Canadian military hospital and cared for by Canadian Nursing Sisters. Nurses in civilian hospitals all over the country are frequently called upon to serve wounded airmen, soldiers, and sailors.

The demand for public health nursing service in shelters and in the devastated areas has become so insistent and widespread that there are not nearly enough fully prepared public health nurses to meet it. The Royal College of Nursing has made a gallant effort to provide short courses in the essentials of public health so that nurses who have had no training whatever along these lines may be able to cope to some extent at least with the appalling conditions described elsewhere in this *Journal*, under the heading of "The Problems of Dispersal". There is certainly less specialization of function than ever before and, in Britain, the slogan of "every nurse a public health nurse" has become more than a pious aspiration.

There are other, though less immediate, problems which are causing British nurses some anxiety. In the face of drastic social change, there is need for clear thinking and vigorous action on the part of all independent professional groups. The trades union movement is playing a magnificent rôle in its legitimate sphere of influence. But, as Mrs. Bedford Fenwick has pointed out, nurses should control their own professional destiny :

> We have just got to look forward to the re-organization of all nursing activities. At present everything is in the melting pot. It will be for the profession to take hold and manage its own affairs when the blessing of peace is secured.

Some English hospitals, in an attempt to bolster up depleted staffs, have admitted girls of sixteen to their schools of nursing. Even though fully trained nurses were available, amateurs have been allowed by various governmental authorities to assume duties which they are not qualified to perform. These and other dangerous practices can only be restrained by vigorous and united professional action which will doubtless be undertaken in due time.

In Canada we have much to learn from our British sisters who are so bravely enduring this ordeal by fire. We are only just beginning to take our places in the front ranks of the battle, but the pace is quickening from month to month. Already our hospitals are beginning to feel the effects of the withdrawal of "key" nurses in increasing numbers as they enter military service; we might do well to note how our neighbours to the south are planning to deal with this particular situation.

— E. J.

The Nursing Care of Mental Patients

MRS. LESLIE A. DIGNAN

First of all I wish to speak of the aims of a true psychiatric nurse. These are fourfold: (1) the recovery of the curable; (2) the amelioration of depression, and of the loneliness and sense of detachment in the lives of the mentally ill; (3) the prevention of (or if too late, the overcoming of) pernicious habits; (4) building a foundation for future mental health, and permanent emotional stability. The requisites for achieving these aims are firm, genuine, and unfaltering interest in the patient; adaptability to the personality of the patient — the art of companionship; poise and quiet self-confidence; a realization of the fact that the voice has a peculiarly marked influence over all nervous and mental patients. It is mental sunlight these patients so sorely need, but this optimism must come from abiding faith and hope, not from a tendency to ignore misery as non-existent.

One of the most important duties of the nurse is to have the patients take a sufficient amount of nourishing food. Many will not eat voluntarily, and resist all efforts of the nurse to have them do so. She should find out, if possible, why food is refused; often it is due to delusions that the food contains poison. This may be overcome, when persuasion fails, by serving the patient, and other patients, from a common supply in the presence of the patient, or by allowing him to exchange plates with someone else. Sometimes, the nurse can gain the patient's confidence by tasting, in his presence, each article of food which has been served to him. Eggs may be cooked in the shells, and potatoes in their jackets, and the patient permitted to open and prepare these for himself.

The patient may also have delusions that he is unworthy to have food, or that he has no money to pay for it, or that it belongs to others, and by taking it they will be deprived; or it may be because of hallucinations in which he hears voices which tell him not to eat. Sometimes they are too busy to eat, and the pressure of activity crowds out the desire for food, or they prefer to sit alone because of delusions that they are unworthy to eat with others. Some will refuse certain meals, and eat others; or refuse one kind of food, and take another. Some patients are unable to decide what to eat first, and therefore eat nothing, unless the nurse is near to decide what must be taken.

Nevertheless, by persuasion, patience, and perseverance, nurses are able to accomplish much. Sometimes a little diversion, like bathing the face and hands, shaking and turning the pillows, smoothing the bed clothes, reading from the daily paper, and magazines, conversing on some interesting subject, and soft music may be used to distract the attention, and make the patient willing to eat. Even against strong desire, many can be persuaded to eat by the nurse who repeatedly tells them that the physician has prescribed the special articles of diet. Sometimes the tray may be left beside the bed, and when the patient thinks no one is looking he will hastily eat all that has been provided. Those who will not voluntarily take food must be spoon-fed, which requires much time and patience. If they resist and will not open the mouth, rubbing the lips with a spoon, or holding a glass to the lips and wetting them, will sometimes help. A small quantity of fluid is poured at a

time, and at regular intervals, for it is important to keep up the act of swallowing. After once beginning to swallow, some patients will take an indefinite amount of nourishment.

When persuasion fails, and all other means are resisted, feeding by nasal tube becomes necessary. The character of the feeding, the quantity, and the intervals, are always prescribed by the physician. The feedings may consist of milk, eggs, sugar, salt, strained cereals, mixed with milk, concentrated broths, and purees of vegetables made thin by addition of milk, also tomato and fruit juices. The feedings are strained, so that particles or shreds will not clog the tube, and are given at a temperature of 98° F. The entire volume of fluids to be given should not exceed twenty-four ounces. The tray should be made ready with towels, a tumbler, glycerine in a medicine glass, any medicine which is to be given, and a basin to be used in case of regurgitation. The tube is boiled and placed in cold water, a pitcher contains the feeding, and a small pitcher of water is also provided. The patient should lie in the dorsal position with head and shoulders slightly raised on a pillow, the arms under the bedclothes beside the body, and tucked in securely. A towel is placed across the chest and under the chin to protect the bed, and a strap sheet across the knees, if the patient is resistant, to prevent kicking. A towel should be placed about the head, grasping it firmly behind or to one side, in order to control and steady the movements of the head. If the patient is very active, the forearms will have to be held to avoid interference with the tube. The feeding is usually given by the physician unless a nurse is instructed to do so in cases where the patient has to be tube-fed for some time.

It is sometimes necessary to restrict the amount of food, for some patients have voracious appetites. If more than enough to satisfy the appetite is given they may hide it in their clothing and later transfer it to their beds, and other hiding places, which may be most unsanitary. All food should be carefully prepared, potatoes should be mashed or cubed, the meat cut in small pieces or put through a food chopper, the bones removed from fish, and the pits from fruit. Bread is served buttered. Soup, tea, coffee, and cocoa must not be served hot, for burns may occur when sensation has been diminished. Cutlery must be carefully looked over, and every piece accounted for after each meal. Patients with actively suicidal and impulsive tendencies are not permitted to have sharp knives or forks; a dessert or teaspoon is used.

Insomnia is a common symtom of nervous and mental disorder, and is usually caused by mental excitement, grief, worry, pain, discomfort produced by heat or cold, indiscretions in diet, and fatigue or the lack of it. Toothache or earache, of which the patient never complains, or an over-distended bladder may also be direct causes. Some of the measures a nurse may take to induce sleep are plenty of fresh air, absolute quiet, dim lights or darkness, a comfortable position in bed, covers not too heavy but sufficiently warm, a hot water bottle to the feet, cold compress to the forehead and eyes, an ice bag placed at the back of the neck, a fresh cool pillow. Stroking the forehead, or forearm, brushing the hair, a warm bath, a cold pack, a tepid sponge, gentle massage of the back at bedtime, followed by a cup of hot broth, milk or cocoa, reading from a magazine or book of poems, or telling a story, playing soft music or singing quietly may also help the patient to sleep. Exercise in the open air is, in many

cases, the most beneficial means of promoting sleep. Hypnotics should be avoided, a dependance upon them is so easily acquired, and many of them produce after-effects, which are not helpful.

Distention of the bladder and colon, due to retention of urine and faeces may frequently occur; this may be the result of paralysis, or of diminished sensation. Serious disorders may result from the re-absorption of toxins which should be eliminated, and sometimes rupture of the bladder and obstruction of the intestine follow over-distention. Regularity in elimination must therefore be established. New habits can be formed, and untidiness can be corrected by following a regular schedule of taking the patients to the bathroom. Measures to induce voiding are the same as in general nursing; if catheterization is necessary a rubber catheter is always used. Constipation should be overcome by having the patient drink water freely, by adding plenty of vegetables and fruits to his diet, and by exercise in the open air.

Patients who are inclined to have seizures of any kind should not be left alone, or without supervision. They may fall out of bed, or fall heavily if up and about the ward or on the street. Because consciousness is lost so quickly they are unable to save themselves from injury. Try to prevent the patient from falling against sharp corners or sharp edges, or upon hard surfaces. Insert a cork, or a padded clothes-pin, or mouth gag between the teeth to prevent the tongue from being bitten. Place a pillow under the head, and loosen the clothing about the neck and waist. If the convulsion is very severe and is prolonged for hours, a general anaesthetic (chloroform) may be necessary to control the violent movements. But it is never administered except by order of a physician. After the contractions cease, the patient is undressed and put to bed. An ice-cap is applied to the head. The nurse should note whether there is a "warning", and its character, and should report where the convulsion begins — whether in the muscles about the mouth, a hand or foot; how the movements spread; how much of the body is involved; whether the contractions are slight or severe; and the duration of the attack.

Much discretion and judgment are required in the management of excited patients, and all cannot be treated in the same way. Some patients are keenly alert to what is going on about them, even though they may be talking loudly. Nurses must be careful about what they say in the patient's presence, as their conversation may make them more excited and suspicious. Some patients become more excited, and even assaultive, if they are touched or handled, but will yield to persuasion and suggestion. With others, no persuasion will make the least impression and measures of restraint may be required to save them from exhaustion, or from injuring themselves, or doing harm to others. The nurse must not hesitate or show fear when in the presence of excited patients, but serenely and steadfastly face the situation. Her calm behaviour and quiet speech will do much towards reducing excitement. It is usually better not to try to repress or limit the activity, but to direct it. The patient, who restlessly rushes from one place to another unceasingly, will probably push a floor polisher placed in his hands and gradually become less talkative and active. Later, he will act promptly upon the suggestion to rest, or take on some simple hand-work, or look at books and pictures. Sometimes playing quick music will appeal to the patient who will respond by marching or dancing, and gradually slower records

may be played and the excitement reduced in this manner.

Whenever it becomes necessary to forcibly carry out orders for treatments, or to restrain activity, it is wise to get as much help as possible, and so avoid a struggle and possible injuries. The mere presence of numbers is often all that is required to gain submission. Always explain to the patient what is about to be done, and gain cooperation by persuasion if possible. If this fails, carry out the order with gentleness and kindness. Having decided upon a course of action it is usually better not to change, or yield to the patient, as this makes obedience in the future less prompt and easy. When it is necessary to hold a patient, grasp him by the forearms, rather than by the hands, as the grasp may be reversed, and the nurses hands may receive wounds from biting. To avoid injuries from kicks, provide soft slippers rather than boots. Do not stand in front of the patient, but hold him from behind.

When camisoles, safety sheets, or any other form of restraint is used, do not tie them too tightly, and watch carefully for swelling or discoloration. Serious injury (such as the loss of an arm) may result from the patient struggling while in restraint. Hydrotherapy has been substituted for restraint measures with gratifying results. Restraint is only used in extreme cases of excitement, when the patient becomes a danger to himself and to other patients.

Suicidal patients must be kept under very close observation, and at no time can they be left alone safely. They must never be out of direct view. Some patients will complain of feeling "blue", and having nothing to live for. Others will never divulge the thoughts which continually are uppermost in their minds, but will sit quietly by themselves, scheming how to carry out their plans, and when least expected may attempt to injure themselves. It should be remembered that suicidal tendencies may be strongest when the patient is becoming mentally ill or is convalescing, and that patients in a mild state of depression may be strongly suicidal.

I will close with a few suggestions to the psychiatric nurse:

1. Treat the patient on the basis of his sanity, rather than his insanity.

2. Remember that appreciation is invaluable when rightly used. Nothing stimulates the growth of good in a patient like the knowledge that you are looking for good in him.

3. Avoid thinking in terms of "punishment". Pernicious mental habits are not broken by punitive measures. When correction ceases to be curative it should no longer be used.

4. Avoid ridicule (one of the cheapest weapons).

5. Avoid hysterical sympathy which sacrifices ultimate good for temporary ease.

6. Do not "coddle" patients by giving them weakening attention.

7. Never agree with, or humour, or verbally combat delusions. Meet them either by diversion, or substitution.

8. Learn to reproduce in writing the peculiar sayings of your patient, for the physician's records.

Nurses who secure confidence of the patients and are concerned with the adjustment of their lives will do much toward the removal of symtoms, and toward their return to normal mental health.

Fire Among the Heather

NORENA MACKENZIE

In her excellent article on "Nursing Education in Canada — 1940," Agnes Macleod gave evidence of a fair amount of fire among the heather. We know the feeling: "there are volumes of nursing Hansard — these are the facts — *let's do something.*" I should like to say a word from the standpoint of an instructor, coloured a little by recent experience as a superintendent of nurses. While the picture is not too pleasant, and the prognosis is perhaps a bit discouraging, we cannot be pessimistic. Every superintendent of nurses rises in the morning and retires at night to the haunting refrain of "my moral obligation to the pupils — and to the care of the patient." It is always with us, and no matter how we analyse the situation the blockade remains the same — finance!

The superintendent of nurses in hospitals which maintain schools of nursing is required to meet two major demands. First, in her capacity as *head of the nursing service*, she must make sure that every patient receives the skilled nursing care which he requires. Secondly, in her capacity as *director of the school*, she must fulfil her obligations to her students. No one knows better than the woman who carries this dual responsibility that these demands are conflicting. Yet it is she who must decide which is to have right of way — the patient or the student nurse.

Some one may very properly ask, if you had to make this decision what would you do? If the situation were just that — the patient or the student nurse — then, of course, *for the time being* there is no choice, because any vacillation in making a decision would proclaim that we had lost our vision. "Who is the most important person in the hospital?" "The patient," replies the probationer. And that will have to be the answer so long as schools of nursing in hospitals are being conducted as departments of those hospitals; it is the corner-stone of our vocational existence.

However, we do not mean that we should smile smugly and say, "Well, that is settled!" The right of the patient to first consideration is in no way inimical to our crusade for progress, nor to the knowledge that good nursing care depends upon good teaching. We have said that the decision was *for the time being* and, while we acknowledge that the primary purpose of the hospital is to care for the sick, we can, I think, concurrently achieve a measure of the primary purpose of a school of nursing — that of an educational institution — by trying to render, under present handicaps, some tangible evidence of what we are about.

It has been our privilege to be connected only with hospitals whose general superintendents and boards of governors were sympathetic toward the school of nursing; and we have seen the slow but steady release of money for the development of the school. In each situation, "better nursing care and greater service" has been the winning trump. As a matter of fact, our observation (plus some intuition) seems to say that *better nursing care* will have to be our marching song. This technique is, according to educational and logical precepts, back to front; and it is the doctrine of empiricism. But we know it works.

First let us accept the debit side of the picture: "One-fifth of all the student nurses in Canada are being instructed in hospitals having a bed capacity of less than 100; 86 superintendents of nurses have had no post-graduate course in either teaching or administration; 44 instructors have had no post-graduate or university courses in teaching; in 14 schools, there is no full-time instructor." In view of these facts, we must admit that there are educational programs in some schools which are unworthy of the name, and also that there is a defensive mechanism, begotten of ignorance or mental inertia. That there should be so many unqualified women in these key positions may seem incomprehensible. However, there is, perforce, a debit side in all professional growth. The international, national and local aspects of mental vigour, economics, and standards of general education will continue to condition all professions. That is the challenge which every generation must meet.

Now let us examine the credit side. In the last ten years, due to the Herculean struggle of great women in our profession who, for the most part, had no university education in nursing or otherwise, Canadian schools of nursing have seen a new heaven and a new earth. Our great women had, and have vision. Through their untiring efforts, post-graduate schools for nurses have been established within our universities which prepare our young nurses to go out into the various fields of nursing education. The result is that schools of nursing from Halifax to Vancouver have seen the organization of teaching departments by these young and vigorous pioneers. The sympathetic understanding and unfailing support of nursing administrators has allowed for what constitutes a beginning of the utilization of every department of the hospital service for the instruction of students. We have become acutely conscious of the fact that before we can give good nursing service we must first educate the nurse, and this has been accomplished by great women who, in spite of obstacles such as some of us cannot comprehend, maintained their singleness of purpose indefatigably.

Of course we realize that we have only passed one hurdle in the race. The methods of clearing the next, as suggested by Miss Macleod, are most worthy of consideration; but as we think about them, the questions which beset us are legion. We must realize that so far our achievements are mainly due to the fact that most hospitals have borne the expense of educating nurses. If and when investigation proves the centralized preliminary course to be sound, can the hospitals be expected to bear more of the financial burden in order that our undergraduate course shall be maintained on a truly professional basis? Even if the student should pay a reasonable fee, will there not still be a large financial overhead to be met? Other professions have the support of the public, either through taxation or voluntary grants. Have we encouraged the public to become sufficiently acquainted with the type of professional service we aim to give?

Concomitant with the better preparation of nurses that we have already obtained, we have witnessed unemployment among private duty nurses, coupled with a large increase in the use of trained attendants. We must recognize the fact that the cost of professional nursing to the patient is beyond the means of most people, and also that the trained attendants fill a real need. What effect will the new

era in education have upon this entanglement? Shall we have two groups within our ranks? Shall we have fewer professional nurses and more attendants? Every facet of the situation must be carefully studied.

We must go forward, but we must also take time to review our position in the light of all the modifying influences of general and specific education. We must know whether financial resources are available for our purpose, and we must have a clear idea of the various fields and types of service. In conclusion, may I quote from Dr. W. C. Graham's splendid article, "A Free and Creative Spirit," which appeared in the November issue of the *Journal*:

To bring this about will call for tolerance, patience, vision and magnanimity on the part of all who have the welfare of society at heart.

Preparing for X-ray Examination of the Upper Gastro-intestinal Tract

MARGARET A. SMITH

The preparation of a patient for an X-ray examination of the upper gastro-intestinal tract may vary slightly in different hospitals, but the underlying ideas and the general aims are the same. The purpose of the examination is to demonstrate lesions of the oesophagus, stomach, duodenum and small bowel. These lesions manifest themselves either through gross abnormalities due to their bulk, such as a large cancer of the stomach, or by disturbance of the physiology of the organ or organs involved, leading to disturbances of motility.

Lesions may not necessarily be within the gastro-intestinal tract. For example, the oesophagus may show obstruction due to extrinsic pressure, that is pressure arising outside the oesophagus, such as large lymph glands or broncho-genic tumour. The examination of the stomach with barium may reveal compression from an enlarged spleen, a pancreatic tumour, or a displacement of the duodenal arc. Among the common lesions of the oesophagus in which X-ray examination is extremely valuable are cancer, diverticulum, oesophageal stenosis, cardiospasm, and oesophageal varices. Whether the symptoms point to disease of the oesophagus or not, measures are always taken to examine it.

The routine barium series of the stomach frequently reveals lesions in the nature of inflammation, neoplasm (benign or malignant), ulceration or deformities; the frequency depends on the expertness of the examiner. The most common lesions of the duodenum are ulceration and diverticulum. In the small bowel, obstruction, paralytic ileus and gross deformities will show up. But, as a rule, barium examination of the small bowel is of less use than in the structures mentioned above.

If intestinal obstruction is suspected, barium obviously should not be used. The patient will need no preparation except that he be turned on his left side for at least fifteen minutes before an

X-ray examination is made. An antero-posterior radiogram is made to determine whether or not free gas is present in the peritoneal cavity. This plate is taken with the patient in an upright sitting position and serves to indicate any fluid level which may be present in the small bowel and to show distended loops of the bowel. A "flat plate" such as this may give as much information and probably more safely than if barium is administered by mouth. In certain lesions, however, such as intestinal tuberculosis, special barium examinations are very helpful in confirming the diagnosis of doubtful cases. As a rule, barium by mouth is not used for examination of the large bowel.

In the Royal Victoria Hospital, the preparation of a patient for a barium series examination includes the following measures: a light supper is given on the day preceding the test; after 10 p.m. no food or medication is given by mouth. The patient must be ready at 9 a. m. on the following morning for the first call to the X-ray department. The following mixture is prepared so that the patient may drink it while the X-ray examination is in progress: barium sulphate, two dessertspoonfuls; malted milk, one dessertspoonful; water sufficient to make eight ounces.

Lateral view of normal stomach, duodenum and a portion of the jejunum showing the barium mixture passing through.

While the patient is drinking the barium mixture, fluoroscopic examination is made of the oesophagus. As the mixture passes into the stomach, fluoroscopic examination is made in order to detect filling defects or any other deformities. When the stomach is filled with the barium mixture, an X-ray plate is taken as a routine procedure. Fluoroscopic examination of the duodenum is also made, and X-ray plates are taken. There is no fixed interval between these successive examinations. This depends on the time which the stomach takes to empty itself and upon whether any pathological or physiological abnormalities are present. Normally, the barium mixture should reach the caecum in six hours. Any obstruction or deformities will show up under the fluoroscope and further examination may be made at desired intervals. Examination of the chest is also undertaken as a precautionary measure.

Instructions as to permission or prohibition of fluids and meals during the rest of the day are sent to the ward with the patient after the initial examination. Sometimes the doctor orders a "follow through" of the barium. In this case, the patient will be instructed to take nothing by mouth and to return to the X-ray department at 2 p. m. and again at 4 p. m. for further examination. On his return to the ward after the final examination he must be given nourishment at once. Many patients experience

a severe headache caused by lack of food, but this will disappear after hot tea and food are taken. We must be sure that the patient is kept warm and quiet. Rest is one of the most essential factors in the treatment of these patients. Unless advised to the contrary, fluids must be forced from now on in order to help the patient to get rid of the barium which remains in the intestinal tract. A cathartic may be ordered at night, or a cleansing saline enema the following morning, to prevent inspissation of the barium in the gastro-intestinal tract.

On admission to the ward, this type of patient usually is found to be a thin, rather pale individual. He seems glad to sit down, and a look of fear may be noticed when he tells you: "I have stomach trouble, the doctor thinks I have a gastric ulcer which should be attended to." He is thankful to get into a warm bed and to rest. If questioned, he will tell you that he has lost weight over a period of eight or ten months and that he now weighs 130 lbs. instead of 160. During this time he has had pain in his stomach after meals, and has suffered from vomiting and constipation. Sometimes the pain has been partly relieved by taking baking soda after meals and, as he had to work in order to support a wife and three children, he did not wish to give in, even though in constant pain. Because the pain came on after meals, he thought that perhaps if he ate less he would not suffer so much. Naturally he lost weight from too little nourishment as well as from the effects of vomiting.

In our nursing care, before any examinations are commenced, it is necessary to keep the patient warm and at rest. Light, bland diet in small feedings is prescribed, and an antacid such as "Amphojel" is ordered in appropriate doses. All meals and medication must

Antero-posterior view of normal colon. The barium mixture has passed through and has descended into the rectum.

be given accurately and on time. The nurse plays an important part in the preparation of the patient and must reassure him, especially if this is his first experience in hospital. He should be given some idea of what will take place when he arrives at the X-ray department, and it should be explained to him that it will be necessary for him to be in a dark room and to be given a barium drink in order that several pictures of his stomach may be taken. The nurse should make sure that the patient understands that he can have nothing by mouth until orders are received from the X-ray department. He should be given a mouth wash frequently, in order to relieve the dryness caused by the withdrawal of liquids. The nurse must remember that a person who is fasting has a lower body temperature than nor-

mal. The added warmth afforded by hot water bottles and blankets is both necessary and comforting.

The nurse should be cheerful and always reassuring. Fear and worry are characteristic of these patients — fear as to whether the ulcer will heal without operation; fear as to whether he may have cancer; fear as to whether he will of necessity be unable to work for sometime with consequent financial anxiety. A great deal can be done by the nurse to encourage and help the patient, whether the decision is in favour of medical treatment only or involves a surgical operation.

Lost Value

BEATRICE ANDREWS

In the year 1871, Bellevue Hospital adopted Florence Nightingale's idea of a nurse's uniform. This consisted of a plain brown linen dress with half-sleeves, a white apron and, on the plainly dressed hair, a white cap. Since its inception, nursing was so closely related to religion that this cap or veil became the symbol of her calling—a perpetual reminder that St. Paul once said that women must cover their heads or be shorn.

Since the opening of training schools, we nurses have earned these caps through hard and unforgettable labour, mentally, physically, and spiritually, with unreasonable and nagging supervisors dogging our steps, correcting this and criticizing that —guiding us (so we thought) the hard way. And that cap always presented itself as hanging in a balance—to get, or not to get, that was the question. Not only to get but to hold!

When we step out of a training school in the full dress uniform of a graduate nurse, the cap means the most of all, and it arouses a keen sense of resentment that this coveted possession should be worn by those who have not earned the privilege and honour of wearing it, but who do so without even asking permission. By "those", I mean hair dressers, waitresses in cafes and restaurants, demonstrators, and instructors of anything but nursing. And I must confess the cap does add a suggestion of glamour to their appearance. Their hair is dressed in the latest style, without the hindrance of a hairnet and a dozen and one bobby pins to hold it in place. There is no one to tell them "no curls on the top of the head, please, it is unbecoming to a nurse". With their neatly-fitting white dresses they remind one of the glamourous creatures (nurses evidently) gracing emergency posters, or such advertisements as: "Is your liver alright?"

What lay people think of the promiscuous use of a nurse's cap it is difficult to know. Perhaps the majority do not even notice. But I do recall a remark passed by a certain lady: "Isn't it funny? These waitresses look like nurses. I wonder why the Nurses Association allows it." That wouldn't mean that something could be done, and that we are shirking, would it? Practical nurses choose their own type of caps and some do not wear one. Graduate nurses wear the cap belonging to their respective training schools, and I see no reason why this cap shouldn't be kept from

public use. The fraudulent use of the letters "R.N." is liable to a $25. fine according to the constitution of the Manitoba Association of Registered Nurses. Perhaps this regulation could be applied to the use of the nurse's cap.

Seeing this cap out of place, in all sorts of places, has been my pet peeve for a long time. A cap should be worn by those who administer to the sick or helpless, and it gives me a feeling of rising indignation when I see it worn by one weighing out nuts, or skilfully balancing dishes on the tips of fingers. It gives me a sense of lost value.

With a R.C.A.M.C. Casualty Clearing Station

Editor's Note: The Journal is indebted to Miss Marion Lindeburgh for the following excerpts from a most interesting letter addressed to her by Matron Agnes J. Macleod, R.C.A.M.C., who is on active military nursing service in England.

We had a glorious crossing so far as weather was concerned. Miss Smellie saw us off at Halifax, and it was so nice having an opportunity of talking to her, although it was all too short. Then Miss Pense met us when we docked in Scotland, and took us under her wing from there on. We came down to London on the night train, and the Neurological group, with Matron Macdonald, went to the Overseas Club. We eight, along with the two from Winnipeg, and two from Toronto, were very fortunate and stayed at the English Speaking Union on Charles Street, just off Berkeley Square.

We were given five days shore leave immediately, and the majority of the group stayed in London. It was really rather unfortunate that we arrived just when we did as the Germans had just nicely launched their air raids on London, and it was impossible to go very far without getting caught by an alarm. Each night they showed us out of our beds to the air raid shelter in the basement, which was comfortable enough for sitting, but pretty difficult for sleeping. Some of us slept on the floor, but after one night downstairs I decided I'd rather take a chance, and slept in the front writing room in two easy chairs, facing each other. It was quite an initiation for all of us, but we were very glad when the cars finally arrived to take us to our own quarters. From September until November we lived in tents, and then moved to where we are now, in winter quarters.

We thoroughly enjoyed our camp experience, although we did feel the cold most frightfully in late October. However we just donned all the woollens we owned, and by degrees became accustomed to the dampness. It certainly didn't hurt any of us, and we all put on weight. The camp was located in a very lovely park area, near an interesting town which we could reach fairly easily. Two of us shared a tent, and we had our own mess tent, and thoroughly enjoyed our meals. As a Casualty Clearing Station, we carried a fifty-bed establishment, and then used

stretchers over and above that. We quite frequently had over ninety patients in camp at one time. Minor accidents, the usual medical complaints, and occasionally an emergency operation. The hospital set-up consisted of an orderly room tent, an admission and discharge tent, a medical service tent, and a surgical service tent. Then there were three to five tents for patients in each service, a cook tent, a dispensary tent, a linen supply tent, pack stores, and operating room tent. In all we must have had well over fifty tents.

It did get pretty cold before we moved, and the last two weeks we were there it rained most of the time, with the result that rubber boots were the order of the day, and the mud was something to deal with. When the order came to move it didn't take very long, although the settling in has really taken a long time. We have four huts completed, and they are all in use, and have a capacity of twenty beds each. It is expected that we will probably have as many more, but at the moment we have as many as we apparently need. The turn-over here is very great, as we are supposed to keep only short term cases which do not need to go on to the general hospitals, and every day we have a goodly number being evacuated, and admitted.

We are in a corps which is partly Canadian and partly British, so that we get patients from a great variety of places, and they all seem so appreciative of anything that one does for them. I handle all the Red Cross articles myself, as we do not have a Red Cross worker. Each time I write to anyone, I mention the Red Cross because it is perfectly wonderful how many things they keep us supplied with for our patients. Every time I really want something for the Hospital which we can't persuade Headquarters to give us from ordnance, the Red Cross comes to our rescue. I think it is rather important that people at home should appreciate how much hospitals over here are turning to the Red Cross. They keep me supplied with comfort bags, wash cloths, soap, tooth brushes, tooth powder, combs, mirrors, razors, blades, shaving cream, shaving brushes, chocolate and cigarettes for the patients. Then besides that, I get sweaters, socks, scarves, mitts, helmets, which I give out to patients who haven't enough when they leave hospital. All our operating room towels, sheets, and dressings are from the Red Cross, and when we asked them for another lamp for the operating room we were given it. So, any time you hear any criticism of the Red Cross, just pass the good word on. We just couldn't manage at all if we didn't have its assistance.

Yesterday afternoon I went in to London for the first time since I left it in September, and I was perfectly astounded to see so little débris lying around. As I walked across Hyde Park, the usual soap box orator was holding forth. Pigeons and sea gulls, and the swans in the Serpentine, look just the same as if nothing had been happening around there these last three months. When we were in London before, everyone looked so strained, but yesterday Oxford Street was festive and busy. It really did me good and quite bucked me up. London certainly can't be broken from the air, no matter how long this may go on. It is a thrill to be here and to see how well they are taking this whole thing, and the way they carry on in spite of everything is perfectly magnificent. What the future holds, we can't predict, but it is a great satisfaction to me to be in this part of the world just now.

Trends in Military Surgery

We have learned as an Empire that this war is truly different from all other struggles—different in its conception of attack and defense, different particularly in the fact that the civilian population is, in certain phases of the struggle at least, more vulnerable to attack than the military personnel. The surgeon, whether he be a member of the forces or the emergency medical services, or even in private practice, is confronted by the same problems of treatment and disposal. Civilian surgeons are treating soldiers, sailors, and airmen in large numbers. Military hospitals, such as our own, have beds set aside for the treatment of civilian casualties occurring in the area. The whole of England and Scotland is a vast military district and it is impossible to find, even in the most isolated neighbourhoods, a practitioner who may not at any time be called upon to deal with emergencies arising from enemy action and thereby constituting a state responsibility.

The problems which the surgeon faces, shock and infection, are those which military surgeons have met throughout the ages. Advances in surgical treatment have been directed along these lines, even as they were in 1914 to 1918. They are being attacked by civil and military surgeons alike. The Home Office, the Ministry of Health, and the War Office work together. The Medical Research Council and the Department of Pathology and Hygiene of the War Office are in close association.

In medical parlance this struggle has been termed a "plaster" war because of the great interest in the closed treatment of wounds. Prophylaxis, pooled blood, and plaster, each one, might well be the subject of a long paper. These terms suggest the advances in treatment as one reviews them at the end of this first year.

Prophylaxis: The French army for two years had been using tetanus toxoid and were convinced it was a dependable safeguard against clinical tetanus. It was their practice to give two immunizing doses to every soldier and a third dose of toxoid immediately after wounding. It is the practice in the British and Canadian army to give the two immunizing doses of toxoid but to administer the usual 3,000 units of A.T. serum following wounds. Some figures have been made available on the incidence of tetanus in the B.E.F. during the spring campaign. This incidence was 0.45 per 1,000 wounded. No case of tetanus was reported in a soldier who had been actively immunized by toxoid.

It has been the practice in the British army to administer a prophylactic dose of sulfanilamide by mouth to all wounded. In certain hospitals the powdered drug has been used locally in wounds, particularly in those cases where it has been impossible to give it by mouth. I have not seen any critical analysis of results of such treatment. From experimental work, however, it would seem that the administration of sulfanilamide either by mouth or into the wound is a justifiable prophylactic measure.

Blood Substitutes: In the months preceding the declaration of war, both in the army and under the department of health, organizations were established for the collection of donor blood in very large quantities. The War Office appointed Col. Whitby to undertake the work at Bristol, and a very large depot was established there with a list of 30,000 donors available. Certain intrepid young ladies flew the blood across the channel to the various hospitals in

France. Large shipments were also made to Norway during that campaign. This depot was also available for military hospitals in England, although in practice during the winter and spring most of them had a list of donors available locally. In spite of the greatest care, with the inevitable delays of military movement, consignments of blood occasionally deteriorated and were useless on arrival. Reactions occurred when the blood was kept beyond four or five days. In the meantime many workers on shock had shown that the red cells were not a necessary adjunct to the intravenous fluids which were given to combat this condition, whether it be the shock associated with haemorrhage or otherwise. The important factors are fluid and proteins.

A worker in London has just published a method of defibrinating the plasma by the addition of calcium and the production of a serum. All this developed naturally out of the previous organization for blood banks. Blood serum has all the merits of whole blood or plasma in the treatment of shock. It has many advantages. With the separation of the erythrocytes the various types may be pooled and the resultant mixture given to a patient without the delay of typing. It contains no citrate or other chemical agent. Its preparation requires the minimum of handling. It can be concentrated either in liquid form or dried to a powder. It can be kept indefinitely (within months at least) at ordinary room temperatures. There are no transportation problems. Blood serum is being concentrated in Toronto in the Department of Hygiene under the direction of the Professor of Physiology and is available to military hospitals throughout Canada.

Closed Treatment: Having done what is necessary to prevent infection generally and to combat shock, the surgeon still has a grave responsibility for the local treatment of wounds. The man's life will depend on the capabilities and judgment of the surgeon who is responsible for the initial treatment. Professor Trueta, of Barcelona, during the Spanish Civil War elaborated and expanded certain principles of treatment announced by Carrel, Dakin, and Winnett Orr in the Great War. He found that this routine, as well as being convenient in a war which involved large centres of civilian population, cut down the mortality from infection. His results, as published in a short treatise in English in 1939, were astounding. So astounding, indeed, that surgeons throughout the world said that the soil of Spain and the climate of Spain must be different, that there were no streptococci or gas organisms there.

I have had an opportunity to discuss this subject with Trueta. He assured me that in the early stages of the war he unfortunately saw many cases of gas-gangrene and severe streptococcal infection. He is a man of the highest integrity. Since working in Oxford, as he has done after being outlawed from fascist Spain, he has convinced his associates of the value of the closed treatment. Briefly, this means debridement followed by immobilization. He does a most meticulous debridement of the wound. This frequently means in bomb wounds that the area must be opened up widely and that all devitalized tissue is cut away. Only in the smaller and more recent wounds is the skin closed. In the great majority of serious war wounds they are left open and the cavity filled with plain sterile gauze or a lightly coated vaseline pack. The whole limb is then included in a plaster cast, including the joints above and below the area, thus ensuring perfect immobilization. The wound is not inspected for at least ten days and sometimes thirty days. The

removal of the plaster, which in the meantime has developed an offensive odour, shows a non-oedematous granulating surface. The whole area is cleansed and the plaster is renewed. The initial operative procedure is followed as a rule by three or four days of fever, but the patients are comfortable and can be transported from the area of immediate danger within a very short time.

Girdlestone and Seddon of Oxford, with whom Trueta is now working, have become enthusiastic, and indeed, all over England so important has plaster become in wound treatment that special manuals and articles are appearing on the training of plaster teams and the economical and careful use of plaster generally. It has even been suggested that dentists might forsake their ministrations to the mouth and in air-raid crises become plaster specialists. Trueta describes the treatment of 1,200 cases of wounds and compound fractures in the Spanish war with a mortality of under 1 per cent.

What are the foundations of scientific fact on which his treatment depends? It is has been repeatedly proved and reported that the removal of dead tissue is the best and indeed the only effective prophylaxis against gas gangrene. He insists on accurate debridement. Experimentally it has been shown that organisms from a wound may be absorbed rapidly and disseminated by way of the lymphatic system to the neighbouring lymph glands and even to the spleen within ten minutes. Experimentally, the flow of lymph in an extremity varies greatly. With an animal's limb at rest it is difficult to extract lymph. Movement or massage for even a few moments accelerates the flow of lymph tremendously. This is attended by an increase in the speed of movement of particles and colloid substances through the tissues. Trueta notes that after each change of plaster there is usually a day or so of pyrexia. Nature can best provide defence locally against infection when the whole limb is at rest. This is the keystone of his treatment.

The closed treatment, aside from affording the best insurance against serious infection, is, of course, of immense value in a war such as the present one. Casualties occurring in a metropolitan area may be treated with the minimum delay in the centres set up in existing large hospitals. Once debrided and plastered, fractures may be transported safely within a few days to the parent or base hospital beyond the area under attack. In civilian practice it may well be that compound fractures could be saved many weeks of hospitalization and tiresome dressings.

It is apparent that the medical services are playing a most important role in the great struggle. Unlike the other branches of the service, we can so far learn little of what is being done in the medical services of the German army. We do not come in contact with them. We do not see their journals. With our increasingly effective air-offensive they will have their problems and difficulties. We do know that their army medical services were completely reorganized shortly before the war on a very practical basis. We may rest assured that the medical services of our own peoples are ready and alert to deal with the trying conditions which face them. In things medical, as in other phases of the war, we know that ultimately the peoples of the English-speaking democracies will not be found wanting in any field of human endeavour.

Editor's Note:

These excerpts are taken from an article which appeared in the December issue of *The Canadian Medical Association Journal*. The author is J. A. MacFarlane, F.R.C.S. (Edin.), Lt.-Col. R.C.A.M.C.

A Current File for Drugs

K. Ethel Gray

Time marches on. And with time march new drugs and new methods. The materia medica textbook of today cannot include the results of tomorrow's research work; nor can all hospitals finance the replacement of the various textbooks when a new edition is published. However, there is a method by which nurses through co-operation and co-ordination can help each other to keep informed and thus keep reasonable pace. In the classroom, the instructor in materia medica emphasizes to the student the importance of knowing the medication she is giving to her patient; but all too frequently no provision is made by the administration for the necessary information to be obtained in the ward, when the intimate relationship of the process of education and experience can be utilized. Learning can be best acquired when the immediate occasion is utilized, and this immediate occasion is when a nurse has to administer a medication which is new to her.

A new drug, like any new experience, is one that is unfamiliar or unknown. This new drug may be in the textbook under new and non-official preparations as, for example, Gynergen; but in addition to the information obtainable therein, experience tells us that Gynergen has also been used with success for paroxysmal tachycardia in an older male patient. On the other hand, the drug may have only been released for prescription and the nurse has no information unless inquiry has been made from the doctor who wants his nurses to be informed so that good nursing care will be available. The pharmaceutical agencies are usually willing to send informative material to the inquiring nurse.

In order that valuable experience can be recorded, and in order that the intimate relationships between the process of education and experience can be utilized, a leaf may be taken from mother's book of methods in cooking. Mother has a card index recipe box about three by four by six inches. Under the letter "B", the daughter will readily find the recipe for biscuits, and can prepare the anticipated biscuits for the evening meal while mother is out. So, on the wards, the supervisor can use the same type of card index box for her current file of drugs. Then when the patient is to receive her medication, the nurse, who may have recently come to the ward from some other service, will read her order and, if the drug is unfamiliar, she can at once refer to the current file for any information that is available. Thus the nurse using this experience, or association of events, will have acquired something of real value in her professional growth, for the immediate occasion has been utilized when learning can be most readily absorbed.

This filing method was used with success a few years ago at the Colonial Hospital, Rochester, Minnesota. As soon as a new (and by new was meant previously unknown) drug was ordered, the student or graduate administered the medication and, after conferring with the supervisor, became responsible for obtaining all the available data on this new medication. Each Monday morning the ward supervisors met with the superintendent of nurses for half an hour in order to correlate their activities in relation to the entire hospital and to the school of nursing. It was at this meeting that a supervisor would report that

a drug not listed in the text had been given by the nurse, and that she was procuring information which would be submitted later. "But *my* nurse is working on that drug, too!" another supervisor might say. In that event, these two nurses would be asked to collaborate with the instructor in materia medica, but the supervisor making the first report in a meeting would continue the responsibility of assembling the available data.

When the material was confirmed and approved by the doctor and the pharmacist, it was typed on a card and distributed to each ward. As an illustration: Sodium Amytal was used for a time and the available data was filed. Then Nembutal supplanted Sodium Amytal. The nurse again submitted her findings on the chemistry, method of administration, dosage, action and reaction or poisonous effects, and this information was confirmed, typed and distributed to the wards. When Sodium Amytal was no longer used that card, by the consent of the meeting, was removed from the file. In this manner the file was kept active, up to date, and easily utilized by the busy nurse. The instructor of materia medica was always anxious to have new material for her file in order that her teaching would also be kept up to date. Furthermore, a new anaesthetic may be used in the operating room and again the nurse would make her contribution.

The interchange of ideas and the cordial relationship between members of the staff are further developments from this filing method for new drugs. The method was discussed with some of the instructors at the School of Nursing of the Vancouver General Hospital a few years ago, and as a result, one instructor (Miss Hazel Keeler, B. A.) reviewed new drugs at the monthly meetings of the Vancouver Graduate Nurses Association. A further expansion was demonstrated at the biennial meeting of the Canadian Nurses Association at Calgary, by the staff of the University of Alberta Hospital. This exhibit represented a room in a surgical department which was both a study room for the students, and the office of the teaching surgical supervisor. The room was furnished with a book-case, study table, chairs, writing desk, and a blackboard. There were various teaching aids including an indexed box, labelled, "new drug box", containing cards describing new drugs, and an indexed "procedure box" containing cards which listed the equipment necessary for the various nursing treatments. On the book-case, was a box labelled "Nursing Journal Index" for *The Canadian Nurse* and *The American Journal of Nursing*. The magazines also had their place in the book-case. A small book-end set, with sides and base of wood, was shown in this set-up to demonstrate how reference material can be kept in each head nurse's office. Each book was fastened by the binding to a chain which was attached to the base of the book-end set.

Reference has already been made to morning meetings of the nursing staffs. Some may remark: "But we haven't time." Details of meetings should be arranged to meet local situations, but a definite time and place for regular meetings is of inestimable value. Actually, time is saved by these regular half-hourly meetings and is thereby used to greater advantage in the nursing care of the patient and in promoting the professional growth of the student or graduate. In addition, the supervisor sees her work in relation to the entire work of the hospital rather then in her own limited sphere. In other words, we see an example of that very precious democracy for which we are now fighting to preserve.

The Hospital Takes Cover

Have you ever noted down as one of your occasions for thankfulness that you are not in hospital in these days, when Goering's baffled raiders vent their spite on the shelters of the helpless sick? And have you ever wondered just what does happen in a great hospital when the sirens go?

Picture the long ward with the shining floor and white beds; the blue-and-white clad nurses performing their ceaseless errands. The telephone shrills, and at the same moment the weird howling of the sirens comes from all quarters of the city roofs. The nurses stop what they are doing and go to Sister, who, in a brief second, allots the duties; two to collect the walking patients and take them to shelters, and the rest to remain on the ward. These latter begin to wheel the beds into the safest corner of the ward, and to stand by, ready at the next sign of danger to lift patients and mattresses off their beds and under their beds. Meanwhile they chat to the patients who pluckily and smilingly respond, chat about films and knitting and good times at the sea before all this happened, about anything in fact but the approaching wings of destruction and death.

The shelter-nurses have given out two brown blankets to each of the walking-cases, one for a skirt and one for a head-and-shoulder wrap; and out we go to the corridor to join the orderly marching throng making its way to the great elevators. Then down, down, down into the deep cellars below the hospital. These always remind me of the catacombs at Rome, even to the electric roof-lights. On the stone floors old carpets have been spread, and we find a little space for our brown-robed flock and all squat down. Probably by now the bombs are falling with their whistle and crrump, and soon the barrage wakes up and the cellars rumble as fire engines dash overhead.

We are quite crowded, and therefore warm. Besides the nurses, looking as cool and fresh as nurses always do, and the blanket-draped patients looking like Trappist monks, there are hundreds of others, doctors, scientists, research staffs, office staffs, students, cooks and ward-maids, cleaners, and people in all kinds of uniforms. There is a buzz of talk but nobody is talking about the raid. We are superbly indifferent to it, though sentences are sometimes drowned by a very near-by crrump.

Upstairs now there is great activity, for the hospital's own A.R.P. staff of wardens, fire-fighters, and first-aid workers are taking care of us. To them, by now, the entry of an incendiary bomb is no more than the intrusion of a wasp to your window. You coolly swat the wasp, and that is that; the hospital warden just as coolly swats the bomb. One of our young messenger-boys at whose feet there fell an incendiary bomb, seeing no one near to help, promptly threw his coat on the bomb and then jumped on it. The bomb went out, and the boy, badly burned, but quite satisfied, was carried away for treatment.

One thing you may be sure of, that however long the raid lasts and whatever damage is done, there will be no excitement in the hospital. Everyone will continue in the calm routine of duty. Down in the shelter a tutor gathers his students around him and talks earnestly about anti-tetanus serum; while a white-coated young man, miles away in thought, examines a microscope slide and makes notes at racing speed.

In a special room urgent operations

are going on. The surgeon works with slow deliberation; the nurses hand instruments and swabs as though no deafening row assaulted them. Up above cooks and staffs, still on duty, tend the kitchens, for special diets cannot be ruined just to please Goering. Occasionally they utter remarks of blistering and defiant humour.

The hospital is functioning, and efficiently; that is all that matters. Some fall at their posts, unnamed doctors and nurses, telephonists, wardens, messenger boys. Night comes, and the shelter is a vast dormitory. Hundreds of young nurses go off duty, and with blankets and pillow go down to the cellar, curl up on the hard floor—and can you imagine what a stone floor under you feels like at two o'clock in the morning —and sleep in heaps with their heads on each other's knees. They wear uniform, for if the worst should come in the darkness, let them be found as British nurses, not as nondescripts in motley night-clothing. Yes, they sleep! Though the racket of the barrage goes on outside blessedly drowning more sinister noises, the shrilling of the "all clear" finds hundreds of tired hospital heroes and heroines sleeping the sleep of the just, until dawn sends them back to their posts and the night staff take their places.

— *The British Weekly*

Nursing Service, R.C.A.M.C.

Two important appointments have recently been made in the Nursing Service of the R.C.A.M.C. Miss Gladys Sharpe has been promoted to be Matron at Camp Borden, and Miss Edith R. Dick will succeed her as Matron of the Toronto Military Hospital. Both nurses are exceptionally well qualified for their new and responsible tasks.

Miss Sharpe was born in Toronto and was educated at Humberside Collegiate Institute. She is a graduate of the School of Nursing of the Toronto Western Hospital and of the School for Graduate Nurses, McGill University. Having won the scholarship awarded by the Canadian Nurses Association, Miss Sharpe took the course in administration of schools of nursing offered in London under the auspices of the Nightingale International Foundation. Prior to entering upon her military nursing service, she held, with conspi-

Courtesy of the Globe and Mail, Toronto

Matron Gladys Sharpe (left) and Matron Edith Dick.

Courtesy of Blank & Stoller, Ltd

These R. C. A. M. C. Nursing Sisters are among the fifty recruited in the District of Montreal, now serving with No. 1 Canadian General Hospital, in England. Matron Dorothy I. MacRae is the central figure in the front row.

cuous success, the position of assistant principal in the school of nursing of the Toronto Western Hospital. Miss Sharpe has always taken a keen interest in the work of nursing organizations. She has served as president of her Alumnae Association and has held office in the Registered Nurses Association of Ontario.

In referring to Miss Dick's appointment, Miss A. M. Munn, director of the Nurse Registration Branch of the Ontario Department of Health, writes as follows:

Another young Canadian, Edith Rainsford Dick, has joined the ranks as a Nursing Sister and has been granted leave of absence from her position by the Ontario Department of Health. Miss Dick, who is a graduate of Johns Hopkins Hospital, Baltimore, and who has had post-graduate training at the School of Nursing, University of Toronto, has been attached to the Nurse Registration Branch of the Department of Health for the past five years as inspector of training schools. Previously, Miss Dick held positions as superintendent of nurses in the Psychiatric Hospital, Toronto, and at the Ontario Hospital, New Toronto.

It would be impossible to overestimate the value and extent of Miss Dick's contribution to the welfare of the nursing profession in Ontario. Those who have worked with her know how sincere her desire has been to assist in the improvement of nurse education. Miss Dick's friends throughout the Province, and they are many, join to wish her Godspeed in her new line of endeavour.

All in the Day's Work

HILDA ST. GERMAIN

At last spring came and the ice had gone out of the river, and I heartily enjoyed the sight of the ice jam in front of the cottage, and the crash of the ice as it came drifting around the bend in the river beside the cottage. One morning soon after the gas car had gone, I received a telephone message asking me to try to get to Mile 69 on the wood train. I got the wood train and arrived at Mile 69 where a man was waiting for me with a horse and buggy. The roads were dreadful, in some places the water being up to the horse's belly, and sometimes the buggy tipped so much that if I had not hung on tight I most certainly would have been tipped out into the muddy water. At last we arrived at the farm which was about three miles from the track and eleven from the Red Cross Cottage. The patient was about thirty-six years of age and expecting her eighth child. She had been in labour all night. The husband told me that in all her previous confinements she had had no one but him to look after her. She could not speak a word of English. The log house was just one big room with a lean-to kitchen. The room was furnished with two beds, a homemade bench, and table. Two tiny children were huddled up in bed with the mother. I had not been there long before I was sure I had to meet difficulties that would require a doctor if the woman's life was to be saved.

Here I was, three miles from the telephone, cut off by roads where a boat would be more useful than a horse, surrounded by people who could not speak English, the next train to Winnipeg would not be until Thursday and this was Tuesday. The nearest doctor was at Whitemouth, fifteen miles away, and the roads so bad he probably would not be able to come. What was I to do? I talked with the patient's husband who did not understand English very well. He wanted to send for some old woman he had heard of and the only way I could stop that was by telling him that if he did, then I would go away. Finally, late in the afternoon he consented to send his son to telephone the doctor at Whitemouth.

So the hours dragged on, the woman getting worse all the time. The croaking of the frogs was continuous, and now and again the dog would bark, and it would be a neighbour walking over from a nearby farm, only to add to the confusion and give foolish advice, which, of course, I could not understand. Finally, one of the sons returned to say that they expected the doctor at nine o'clock and that the other son had remained behind to drive him over. My hopes rose at that — help in sight. Perhaps all would be well. So we settled down to wait. The man fell asleep beside five children on the vacant bed. Nine o'clock came and no doctor. Ten, ten-thirty, then suddenly the dogs all started barking, and from my heart went up a prayer of thankfulness, "Thank God, the doctor, the doctor". But it was not the doctor, only the other son had returned to say the doctor had not been able to get through, the roads were so bad.

And so the weary night wore away. Home looked far off to me, weary after a hard day, and what might happen ere I could see home again? Must I leave a double tragedy behind me of the loss

of mother and babe? No, no, that must not happen, but what could I do? The woman's strength was failing. I gave her strychnine, did all I could for her and turned over in my mind what I should do. Even if I sent them to telephone to Winnipeg for a doctor, what doctor was going to come 70 miles to an unknown place answering the call of an unknown person? And I could not go to the phone myself. Then I thought — "I know, Dr. Wadge will come, and ask questions afterwards". Just as the first pale streak of dawn was peeking in at the window, I roused the boys and told them to hitch up and go to the telephone. I had written down the number and the message for them. If the doctor got the message in time, he could catch the gas car which left St. Boniface at 9 a. m. but, would he be in time?

The weary hours dragged on again. The children got up and started for school, the man went out to do his chores, and I started my second day, but with new hope which made me feel less tired. I again administered a sedative, trying to save the patient's strength until the doctor got there. The time seemed endless. If this woman should die, I could not stay on at the Red Cross Station. It would be too great a strain on my nerves at every case to which I must go. At last a welcome sight — we saw the old buggy coming and the doctor sitting up beside the boy. He came in looking so capable and confident that all my troubles seemed gone. He soon had us all busy, making himself at home with poor conditions. He went to the kitchen and returned with two soup plates to use instead of basins, and with these and the basin I had brought with me we managed very well. A new surprise awaited us. When I pulled out the bed to get behind the patient to give the anaesthetic, two hens, who were sitting on a box of eggs under the bed, flew out. Maternity under ideal circumstances!

Was there ever more welcome cry than the cry of that babe, though for a time we thought it would not cry at all? The doctor had been operating that morning and could not come by the ordinary train service. He had come by special car and would return at once. But now that everything was alright I did not feel tired any more. I stayed and made the patient comfortable and attended to the baby, and then once more the tired old horse started off on that six-mile journey.

The patient's husband gave me some cream and eggs when I was leaving, and I said to him: "You should be very thankful to that doctor for coming all that way. If he had not come, your wife would have died". He replied: "I am thankful to the doctor and to you too. If you had not been here I would not know where to send for doctor". I think thanks was all Dr. Wadge got.

I paid this woman one more visit, and it took me the whole day to make the journey as we had to go by wagon. The mother and babe were doing well, and one of the sons drove me home. It was now the end of April and the roads were still very bad. The boy beside me could not speak a word of English, but I did not mind. We had to drive sixteen miles through lovely forest, trees just showing a faint feathery green, birds darting about, the pretty blue jay, red-headed woodpeckers, and I noticed a lovely bright blue woodpecker, almost as big as a pigeon. The ground was sandy and the water in the ditches looked so clear running over the sand. Now and again we drove beside the river and it seemed to me as though it sang a happy song. At one place we came to, giant boulders formed a dam across the river and the water was rush-

ing over them, throwing up rainbow spray. Two little bare-foot boys stooped down on the river bank and caught fish with a snare as they came over these boulders. The drive was like a story from a fairy book.

In the early part of the year, the body of a man had been found hanging in the trees near his home. He had been missing from his home for a year and his wife and family had been taken care of by the Child Welfare Association. The family consisted of four girls and a boy. The woman could not speak English, and when questioned about her application for a grant under the mother's allowance legislation, did not know where she was married or her name before she was married, and didn't even know the ages of her children, so you may judge of her intelligence.

One day early in May we had an exceptionally heavy fall of snow, and I was shovelling my way out of the Cottage when this woman surprised me by coming to me and saying in excellent English, "My baby sick all over the back. You come quick". We had great difficulty in getting to the farm through the deep snow, but I found the poor baby sitting on the cold floor absolutely naked with a bad scald all over its back and the back of the neck. It must have been scalded at least twenty-four hours before, but the mother said, "I do not know how it happened". I had serious doubts about the woman's sanity, so I dressed the poor little thing's back, and then went to the school. I told the elder girl, Mary, to stay home until I could get in touch with the Child Welfare visitor.

The weather then became very hot and all the snow was gone in a few hours. The telephone was out of order and we only had mail once a week. Nearly two weeks had gone since the child was burned. Mary brought her twice to have the burn dressed and it healed well. On the twenty-fourth of May (a very hot day) I was awakened by a knocking at the door, and there stood Mrs. B. with baby Dora in her arms. The child was just wearing a little shirt and an old woollen bonnet, and was covered with mosquito bites. The woman put the child in a chair, then turned to me and said: "This is not my baby, it is your baby. You keep it". Then she turned and went out of the door as fast as she could go. Of course, I kept the baby. The poor little mite slept nearly all that day. I had her for a month before she was taken to the Children's Home with her little sister.

A few days later the Child Welfare visitor came down, and oh, what a journey we had crossing the swamp to the cottage, with the mosquitoes buzzing around us like a cloud. We had to take an interpreter with us, but it was evident the woman was not fit to have her children and she refused to move nearer the track where she would be near neighbours, who would notice if there was anything strange about her behaviour.

We came back and scoured the countryside for suitable homes for the children. Finally, we found places for all of them, but how to get the woman? We did not wish to have to arrest her both for her own sake and the sake of the children. At last two women agreed to go and get her to come to the track so that she would be there just as the train came in. Once we had her on the train our troubles would be over. The train left at eight in the morning so it meant an early start for the two women to make the six miles return journey. And, oh, how it rained! They all got to the track just as the train came in, wet to their skins, but the woman got quickly on the train, believing it to be the only way to get rid of the baby which she

insisted was not hers. She was sent to Selkirk Mental Hospital and is still there. The second girl, Mary, is working and doing well, as is the elder sister. The two little ones are in the Children's Home and the boy is still with the people who took him when his mother went away.

Health Teaching in the Schools

I was surprised and very pleased to read Mrs. Redfern's article on "Teaching a Home Nursing Class" in the November issue of *The Canadian Nurse*. Mrs. Redfern is one of a number of nurses who, after teaching the Red Cross Course to a group of collegiate students, has felt keenly that this instruction, given by a qualified graduate nurse, should be included as part of the study in every secondary school.

I thought that the readers of the *Journal* might like to know something about the health teaching that is now being given to the students of secondary schools by voluntary nurses who teach the course in health, home nursing, and emergencies for the Ontario Division of the Canadian Red Cross. For many years we have organized classes, after school hours, for the girls of secondary and normal schools. In many of the larger cities, Red Cross Home Nursing, as an extra-curriculum class, became recognized as routine, year after year. We found these classes so appreciated by both the principals and students that in order to give as many secondary schools as possible the privilege of having the course, we asked permission to write the school principals offering our assistance in arranging extra-curriculum classes taught by a nurse. Dr. Duncan McArthur and Dr. G. F. Rogers were both very interested and co-operative. In his reply to the request, Dr. Rogers said, "The fact that these classes are conducted by specially qualified persons, such as doctors and nurses, makes it possible for topics to be discussed which are not included in any of the courses of the regular school curriculum, and which the members of the school staff are not prepared to teach".

In 1939, Dr. F. W. Routley wrote the principals of secondary schools in Ontario, offering the service of the Red Cross if they wished to have the health, home nursing, and emergencies course as an extra-curriculum class. A perfect deluge of letters came in from interested people — commendation from those who had already had the course, and inquiries from those who wished to have it. Last year, there were sixty-six secondary schools in Ontario that had this course, ranging from one to twelve groups in a school. We know of only one school that has a full-time nurse teacher on the staff, but from time to time we hear of more schools that have given time during school hours to have a public health nurse teach health, home nursing, and emergencies.

The voluntary nurses who have so ardently wanted this concession will feel amply repaid if, each year, just a few more schools give it a place in school hours. Just at this time, what better service can a nurse give her country than to help instruct these intelligent young people who, uniformly taught, and under the direction of the principal, should be a very valuable group were their services to be required.

— MARION H. HENDERSON

Notes From the National Office

Contributed by JEAN S. WILSON,
Executive Secretary, The Canadian Nurses Association

In the January issue of the *Journal* these Notes stated the Committees by which several projects in national organization work are carried on. In this issue reference is made to developments in the programme of two committees.

The Sub-committee on Schools of Nursing Records: Now that the Proposed Curriculum for Schools of Nursing in Canada with its Supplement is available, it is most important that as soon as possible a unified system of records should be developed for use in Canadian schools of nursing. The organization of the Committee on Nursing Education includes a sub-committee on schools of nursing records. The convener of this sub-committee is Ruth Thompson, director of nursing, Belleville General Hospital, Belleville, Ontario. Miss Thompson, who secured her degree as Bachelor of Science in Nursing at the University of Alberta, is also a graduate of the course in teaching and administration of the School of Nursing, University of Toronto. Her administrative experience and particular interest in records fits Miss Thompson specially well to convene this very important project of the National Organization.

This sub-committee of the Committee on Nursing Education faces a difficult task, the achievement of which will depend to a great extent on the effort and co-operation of the provincial associations of registered nurses. Therefore it is necessary that the plan of organization should be strong, and the personnel selected to assist in this work, qualified and experienced. Each provincial association has been invited to appoint a representative to the sub-committee on records. When issuing this invitation it was recommended that each provincial representative should be preferably a superintendent of a school of nursing, who, as principal of one of the more progressive schools, is most qualified to become a member of this sub-committee. In general, the responsibilities of the provincial representatives will be in the nature of collecting sample records and in assisting the convener in the process of evaluation relative to the construction of a set of records, to be approved finally by the Canadian Nurses Association.

History of Nursing Committee: This committee was appointed at the general meeting in 1938 for the purpose of (a) studying the question of the preparation of a History of Nursing in Canada and (b) to collect data and material for such preparation. This committee, convened by Mary Mathewson, assistant director, School for Graduate Nurses, McGill University, was reappointed at the time of the general meeting in 1940. The conveners of corresponding provincial committees are members of the National Committee. The provincial committees are responsible for the assembling of historical material. The biennial report of the History of Nursing Committee for 1938-1940 recommended that the preliminary phase of assembling and collecting material

should be continued for another two year period; also that when provincial committees reach the stage where clerical assistance is necessary in order to proceed with the work, financial assistance not to exceed fifty dollars per province may be granted by the Canadian Nurses Association on the recommendation of the Convener of the National Committee. These recommendations were approved so that now the provincial committees are working toward the completion of assembling authentic data regarding the beginnings of hospitals, schools of nursing and public health organizations.

To those who have completed this preliminary work, it has been suggested that the material collected be classified. When the latter has been done it will be possible to see where further work is necessary, due to inadequacy or incompleteness of information. Also, it has been proposed that a special search should be made for illustrations and photographs, particularly those relating to the earlier days, as well as for biographic sketches of pioneer nurses in Canada. It is recognized that the earlier graduates of Canadian schools of nursing may have valuable and interesting pictures and documents in their possession. While these nurses might not be willing to donate such historical treasures to provincial committees, doubtless they would consent to have each article listed in a provincial office in order that the material may be available for loan when the actual writing of a history of nursing in Canada is undertaken. Such a list should include a brief description of each article, the owner's name and address as well as any relevant particulars.

Recently the Overseas Nursing Sisters Association of Canada informed the Executive Committee of the Canadian Nurses Association of their desire to co-operate with the History of Nursing Committee by supplying a record of nursing services during the first World War. The preparation of this record is being undertaken by Margaret Macdonald, formerly Matron-in-Chief of the Nursing Services of the Royal Canadian Army Medical Corps.

In times like the present it is more important than ever that effort should be made to preserve what is best and finest in the traditions of the nursing profession, as exemplified by the achievements of pioneer Canadian nurses. With this in view, the work of the History of Nursing Committee takes on new significance. Under these conditions Canadian nurses should feel stimulated toward playing their part in preserving a record of professional development for the inspiration and guidance of future generations.

Nightingale Memorial Fund

Contributions to the Florence Nightingale Memorial Fund have been received from:

British Columbia:

British Columbia nurses $25.00

Quebec:

Student Government, School of Nursing, Jeffery Hale's Hospital Quebec City 5.00

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

What is Public Health Nursing?

LYLE CREELMAN

Secretary-Treasurer

Public Health Section, Canadian Nurses Association

Not many decades ago public health nursing was limited to the care of the sick in the homes. We all know the story of the origin of visiting nursing in Liverpool when William Rathbone, after realizing the value of a nurse in his own home in caring for his sick wife, conceived the idea of such a person visiting in the homes of the poor. From the very first education for more healthful living was emphasized. To-day the public health nurse in the community has many activities which, in those first years, would never have been considered as her function. She is the connecting link between hospital and home, health department and home, school and home, industry and home. She visits not only the homes of the poor in the slums of our cities but she visits, and is welcome, in the homes of rich and poor alike, in cities, rural communities and on the frontiers.

There have been enormous advances in the science of medicine and disease prevention in the last fifty years. The average life expectancy has been extended and many communicable diseases almost eliminated. Much of the credit for this is due to the research worker, laboratory technician, physician, surgeon, dentist and chemist, but along with them the public health nurse has played no small part for she is the person who translates the language of these scientific workers into the language of the ordinary citizen, she carries this knowledge into their homes and assists them in applying it to their every day situation.

The public health nurse is essentially a teacher, both by word and by action. Day by day she must drive home simple points about feeding babies and children, about the value of immunization procedures, about the care of the patient whose sickness is a menace to the family group. In attempting to drive home these commonplace facts she encounters all kinds of resistance. She has in her class, people with wide degrees of educational background and also with various amounts of native intelligence. There are all age groups and all social classes. The public health nurse, as their teacher, must meet the resistance of ignorance due to a low degree of intellectual equipment. Frequently there is the resistance based on tradition and custom, and

worst of all is the resistance based on the lack of a desire to know and to believe. It takes much patience and renewed efforts to try to overcome these obstacles and often the nurse must conclude that she is dealing with uneducatable material. This is not an evidence of lack of ability on the part of the nurse — rather she is to be commended when she recognizes the situation and uses her time and efforts for those who have a will to learn.

With the assumption of more and more activities by the public health nurse and with more of these being carried on under official agencies, there has been a tendency to exclude the care of the sick in the homes from the duties of the public health nurse in the official agency. At the same time we have become too didactic in our teaching — we have been telling and not demonstrating sufficiently. There is an increasing recognition, among the leaders in nursing, of the educational opportunities offered in the care of the sick in the homes. There is a need which the nurse can meet — she is being asked to give a service. This paves the way for further health education in such a manner as is impossible when the initiative for the first visit is made by the nurse herself. It is to be hoped that the day is not far distant when public health nurses in all official agencies will teach by demonstration, some members of the family group, to care for the one who is ill.

What of the preparation of the public health nurse? When Mr. Rathbone called a nurse into his home it was probably sufficient for him that she had graduated from a recognized training school, or perhaps even that she had demonstrated her practical ability for caring for the sick. It is very different to-day. Graduation from an accredited school of nursing is not enough for the nurse who is to enter public health. This branch of the profession demands qualities that are called for by no other group in the nursing field. For these she needs special equipment which can only be secured by taking a recognized course in public health nursing which gives practical experience under supervision, as well as theory. This she must have before she can justly call herself a public health nurse. Having graduated from such a course, however, her education in public health is by no means complete. Through individual reading, staff education, refresher courses, she must keep abreast of new knowledge and new methods in her own field as well as in that of education and social work. There will always be new developments demanding her expert guidance. For example with the increased life expectancy the study of geriatrics (the treatment of diseases of old age) is demanding attention, and soon we will have medical specialists in that field as we now have in pediatrics. There, too, will be a new challenge to public health nursing.

It has been said that the measure of the public health nursing service is the best measure we have of the health status of a community. An objective of our Public Health Section relates to the promotion of public health by a high standard of service. The efforts we make and the ends we attain depend on the quality of the public health nursing personnel of Canada. It is ours to hold it high.

To be continued!

The Problems of Dispersal

The recommendations of Lord Horder's Committee on the various shelter problems have been put into practice to some extent before they were made public. Though there remain some problems which will be solved only with time and experience, no committee of enquiry has ever made a report and had it acted upon by the Government in so short a time. Yet the committee is still profoundly disturbed by conditions. The suggestion of greater dispersal of the shelter population is stressed as the crux of the problem. It is dependent on increased evacuation on one hand, and fuller use of surface shelters of the Anderson and brick varieties, and of factory or commercial shelters not in use at night on the other.

The evacuation of women and children has increased as a result of house-to-house visiting, but nevertheless there are over 100,000 children still in the London area. They are getting, for the most part, no education; they spend at least 14 hours out of the 24 in some sort of shelter; it will soon be 15 hours, where it is not so already. This is no suitable life for the young child and the health visitor should be able to help secure evacuation, if she can make contact with the families she knows.

The shelter problem is still not so easy as it may seem, and leaves us on the horns of a dilemma. On the one hand there is the danger of overcrowding, with the risk of the spread of respiratory diseases such as influenza, the common cold, tuberculosis and measles, of diphtheria, scarlet fever and cerebro-spinal meningitis. With the air of the overcrowded shelter moist and hot, droplet infections will spread the more readily and the nasal mucosa will be the less able to fight against them.

On the other hand there are evils in the shelter for the family whether it be the Anderson or the brick surface shelter with bunks, even when it is complete with door and key. It may be overcrowded to a similar degree: where this is not so, chill and damp endanger health in this climate where rheumatism takes such a heavy toll of health at any time. We can scarcely consider the problem solved unless we can offer warmth and dryness. These two problems are of themselves of considerable magnitude. The suggestion of a candle under a flower pot, though undoubtedly "quite helpful", is not very reassuring as a method of heating.

Even though the problems of overcoming damp and cold can be solved, there are still two points on which the Anderson and the surface shelter fail. In the first place, there is no question but that to some the companionship of the communal shelter is of undoubted value in combating fear. The herd instinct is a natural instinct in the animal world. Men have always, from the earliest days, sought safety and protection by collecting together in numbers. There is no question but that the greater sense of security which comes from contact with others has helped to prevent panic among certain types of shelterer, and enabled the average individual to conceal and master the terror which the sounds and sights surrounding them today might well produce.

And here we touch another of the advantages of the deep shelter which the surface shelters do not give, the freedom from the noise of falling bombs, gunfire and droning planes. True, the alternative is the ear plugs, but these can scarcely be expected to give the same psychological sense of security as

depth. In Spain, the deep shelter was found to be a life-saving means of protection. Birmingham has just declared itself against them on account, we believe, of the danger of overcrowding and infection.

— From *Nursing Times*

National Office Conference of the V.O.N.

A conference of the National Office supervisors and the superintendents of the larger branches was held recently at the National Office of the Victorian Order of Nurses for Canada. Miss Maude Hall, acting chief superintendent, welcomed the nurses attending the conference and expressed regret that Miss Elizabeth Smellie, Matron-in-Chief of the R.C.A.M.C., who was granted leave of absence from the Order in June, could not be present.

Miss Hall outlined the work done by the Order in the first nine months of 1940 and reported that 66,637 patients had been nursed. She also told of the unusual number of changes of staff in the districts, there having been 14 staff vacancies and 10 vacancies for nurses-in-charge in the past two months. Six nurses were granted leave of absence for military duty.

Topics of national and local interest were discussed. It was noted that there was a scarcity of nurses trained in public health nursing, and the question of filling staff vacancies was considered. A discussion was held on the present ruling for pre-employment medical examinations for nurses, namely: "Periodic health examinations of the staff, including a chest X-ray, are required biennially until the age of forty and there after the health examinations annually and the X-ray as indicated." Ways of reducing the weight of the bag by using lighter equipment or reducing the amount of equipment were studied. Alterations in the uniform also received attention and models of the dress and coat were displayed.

The advantages of an exchange of nurses between the Victorian Order branches and also between hospitals and Victorian Order or other health organizations were considered, and it was decided that nurses entering into the exchange should be chosen carefully. The nurses present were asked to consider the project in the light of possible future development, or at a time when staffs were more stabilized. Methods of supervision and efficiency reports were studied. It is hoped that at some time in the not too far distant future a representative committee from large and small districts might be formed to evolve a plan that would serve as a guide to increase efficiency for both supervisors and staff nurses.

Apart from the interesting round table discussions, there were several enjoyable social functions. Mrs. Blackburn, convener of the Advisory Committee on Nursing, was hostess to the nurses at a luncheon at which Miss Smellie was present. Miss Alice Ahern entertained at the tea hour, and a dinner was held at which Miss Gladys Arnold, Canadian Press Correspondent, told of her experiences in Paris at the time of the capitulation of France. Mr. R. B. Farrell, dramatic editor of the *Ottawa Journal*, was the speaker at a

luncheon, when his subject was newspaper publicity in health work. Mr. Farrell said it was necessary for the nursing organization and the newspaper to have a bond of mutual interest and to know how they can help each other. Miss Alice Ahern, assistant superintendent of nursing, Metropolitan Life Insurance Company, discussed the Company's health literature.

The nurses were graciously received by His Excellency the Earl of Athlone, and Her Royal Highness Princess Alice at tea, at Government House, thus bringing to an end one more pleasant and profitable conference.

R.C.A.M.C. Sisters to the Rescue

All Canadian nurses were proud to hear that our R. C. A. M. C. Nursing Sisters on military duty in England had had a share in caring for the victims of the barbarous air raid which almost destroyed the city of Coventry. Fourteen Sisters took charge of more than 150 children who were received at a hut hospital, not yet completed for military use. The poor youngsters arrived one night in ambulances and buses without clothing other than what they wore. A wonderful story of courage comes from the house governor of the Coventry and Warwickshire Hospital. We quote from the *Nursing Times*:

Two big fires were started and the emergency dressing store, which adjoins a ward block, was hit by incendiaries and the fire spread rapidly. Almost immediately the main dressing store was also hit and was soon blazing fiercely. Onwards, throughout the night, bombing was incessant. We fought fires in various wards; patients were moved from one building to another — always just in time, and miraculously there were no casualties among the hospital patients or staff. Soon after midnight the electric current failed but operations were continued in three theatres with the emergency lighting. Then the windows of two theatres were blown in; it was too cold to continue operating in these but work was carried on in the one theatre.

As the night wore on it became bitterly cold in all the wards, as every window had long since been blown out; extra blankets were issued. Every few moments we had to throw ourselves on the floor as tremendous explosions shook the buildings. The one operating theatre in use could not cope with the large number of cases transferred from the reception hall, and casualties covered almost every foot of floor space in the lower rooms and corridors. The staff and patients were magnificent. There was never a sign of panic, and several of the male patients were continuously in the grounds, putting out incendiary bombs.

In one ward, badly shattered by a high explosive bomb less than 20 yards away, patients who could not be moved were lying in their beds and watching the aeroplanes in the sky, which was aglow from the fires in the city.

There were over a thousand casualties in Coventry that night, and staff and patients at the hospital must indeed have been magnificent to carry on.

Book Reviews

Community Hygiene, by Elizabeth Soule, R. N., M.A., Professor of Nursing Education, University of Washington; and Christine Mackenzie, R.N., M. A. 212 pages. Illustrated. Published by The Macmillan Company of Canada, St. Martin's House, Toronto. Price $2.00.

The aim of this book is to afford an introduction to public health, and is primarily intended for the use of student nurses. Six of its ten chapters deal with the history and development of community hygiene practices, including food and water supply; sewage disposal; housing; and the control of communicable diseases. A special chapter is devoted to the consideration of community health problems in relation to maternity, infancy, and childhood. The chapter describing the activities of official health agencies is not altogether applicable in Canada, but the book as a whole could be used to advantage in our schools of nursing.

Essentials of Medicine, by Charles P. Emmerson, Jr., M.D., Research Fellow in Medicine, Harvard Medical School; and Jane Elizabeth Taylor, M.Ed., assistant professor of medical nursing, Yale University School of Nursing. Fourteenth Edition, thoroughly revised. 900 pages. Illustrated. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Building, Montreal. Price, $3.25.

This admirable text, first published in 1908, has now become a classic. Sections describing specific nursing care have been re-written by Miss Taylor. New concepts and modes of treatment in diseases of the skin, allergic conditions, endocrine glands, and metabolism are discussed at some length. Special attention is given to the dietary aspects of therapeutics. The title of this volume is truly descriptive because it really does give a clear and comprehensive outline of the essentials of medicine, thus affording a rich background for the study of specific nursing skills.

Surgical Nursing, by E. L. Eliason, F.A.C.S.; L. K. Ferguson, F.A.C.S.; and Evelyn M. Farrand, R.N., B.S., Instructor in Surgical Nursing, University of Pennsylvania Training School for Nurses. Sixth revised edition. 662 pages. Illustrated. Published by the J. B. Lippincott Company; Canadian Office: Medical Arts Building, Montreal. Price, $3.25.

This book affords a comprehensive survey of surgical nursing, the subject matter being arranged in thirteen units. The first serves as a general introduction to a variety of topics, including anaesthesia. The thirteenth unit deals with operative aseptic technique, and the remainder are, for the most part, grouped about the surgical conditions directly associated with the various anatomical and physiological systems.

One unit is devoted to a discussion of nursing in surgical communicable diseases, including tetanus, gas gangrene, syphilis, gonorrhea, and tuberculosis. There is an excellent chapter on post-operative complications, and another on new and difficult procedures such as the Wangensteen and Miller-Abbott suction apparatus. The illustrations are excellent and add greatly to the clarity of the text. A close integration has been made with "Essentials of Medicine" (reviewed above) thus making it possible to arrange a combined course in medical and surgical nursing, if so desired.

Common Procedures in the Practice of Paediatrics, by Alan Brown, M.D.; and Frederick F. Tisdall, M. D. Third revised edition. 305 pages. Published by McClelland & Stewart, Limited, 215-219 Victoria Street, Toronto. Price, $5.00.

This book constitutes a detailed description of diagnostic, therapeutic, and dietetic methods employed in the Hospital for Sick Children, Toronto. Some of the chapter headings are: history taking; physical examination; the undernourished child, special dietary procedures; therapeutic and diagnos-

tic procedures; biological products in the diagnosis and treatment of communicable diseases; laboratory procedures; difficulties in diagnosis; drugs.

While this book was not written expressly for nurses, it contains much information which is of interest and value to them. This statement particularly applies to the chapters dealing with the feeding of infants and older children. All public health nurses, and especially school nurses, will find the chapter on behaviour problems very enlightening.

Correspondence

From a Red Cross Outpost

Miss Audrey Lamb, a graduate of the School of Nursing of the Royal Victoria Hospital, Montreal, is in charge of the Red Cross Outpost at Port Loring, Ontario. Judging from this letter addressed to Miss Grace R. Martin, her work requires considerable versatility as well as skill and devotion:

Red Cross Outposts are always situated in isolated areas and Port Loring is no exception. We are about forty miles from a railway and mail comes in three days a week by stage coach. The main industry is lumbering and with few exceptions the people are poor.

The regular staff at the Outpost consists of a housekeeper and myself, and a part-time chore boy who lives at his home. We have accommodation for three adults, one child and a nursery, but we never refuse admission to sick patients so we sometimes have to resort to couches and borrow baskets. Not long ago we had four mothers and four babies. The babies occupied our dining room and we had to eat just everywhere. We have mostly obstetrical cases but we occasionally have medical, and everything else that turns up in the community requiring hospitalization.

Besides the in-patients, I have at times quite a busy out-patients service and well baby clinic. Occasionally I do bedside care in the home and frequently assist the local doctor with home deliveries.

Last summer we held a tonsil clinic and engaged the services of a nose and throat specialist from the city and had seventeen tonsilectomies.

During the spring and fall I have to examine the pupils in eight school rooms, and then follow-up teaching calls have to be made on all who have defects. I usually do this when I have a student from Toronto University School of Nursing public health class with me, which is usually in May and September.

A local Red Cross board is responsible for the upkeep of the Outpost and we had a very successful field day to raise funds for this purpose. As you see, there is a great variety in my work and I find it very gratifying.

The Journal Takes a Bow

Although they are all too seldom in the limelight, the nurses who direct and serve in small hospitals are making a most valuable contribution to Canadian community life. Among these nurses is Marion Petty, superintendent of the Lord Dufferin Hospital, Orangeville, Ontario. We know from experience how full her day must be, and yet Miss Petty found time to send the *Journal* this encouraging message:

With each number, the *Journal* becomes more interesting and instructive. I only wish it could be incorporated into the necessary requirements of a graduate nurse, as so many younger nurses do not realize the importance of supporting the official or-

gan of the profession, nor do they realize what it has done for them. The writer has been a constant subscriber since graduation in 1922, and almost all the intervening years have been spent as a superintendent of small hospitals in Ontario, both with and without training schools. I am therefore in a position to know the needs of the younger graduates, and instructive reading is one of the greatest.

From Down Under

Then in the very same mail, came this letter from Miss E. R. Bridges, nurse instructor in the New Zealand Department of Health :

We use *The Canadian Nurse* and the Proposed Curriculum for reference in the post-graduate course, and find both of them invaluable. Your Convention issue of the *Journal* was particularly interesting and useful. We are carrying on as usual, as far as the post-graduate course is concerned, because Hospital Boards are finding it necessary to prepare nurses to relieve others who are going overseas. The public health and new medical social courses are also well supported.

Didn't we tell you that the members of the British Commonwealth of Nations are getting closer together every day?

Obituaries

ELIZABETH MCKAY SARGENT — (Class of 1894, Farrand Training School for Nurses — now the Harper Hospital School of Nursing, Detroit, Michigan) died recently at Tacoma, Washington, following a long illness. Prior to her marriage, Mrs. Sargent rendered exceptionally fine service as superintendent of nurses and principal of the School of Nursing of the Winnipeg General Hospital. She was greatly beloved by her students, to which she was an unfailing source of inspiration.

ISABELLE HENDERSON, a graduate of the School of Nursing of the Royal Alexandra Hospital, Edmonton, Alberta, and a member of the Class of 1923, died on November 11, 1940. Miss Henderson was born in the Shetland Islands, and began her training soon after coming to this country. At the time of her graduation she was awarded the scholarship by the Alberta Association of Registered Nurses but unfortunately was unable to use it. For a number of years she held the position of night supervisor at the Galt Hospital, Lethbridge, Alberta, and later decided to give up institutional work on account of her health. Miss Henderson was respected and admired greatly by all those with whom she came in contact.

MRS. WITZEL (née Schell) died recently, after a short illness. Mrs. Witzel was a graduate of the School of Nursing of the Kitchener and Waterloo General Hospital, and a member of the Class of 1929.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Miss Betty Morrison has been appointed to the East York staff. Miss Morrison is a graduate of the school of nursing of the Winnipeg General Hospital, and of the public health nursing course at the school of nursing, University of Toronto.

Miss Joy James has been appointed to the Cornwall staff. Miss James is a graduate of the school of nursing of the Toronto Western Hospital, and of the public health nursing course at the school of nursing, University of Toronto.

Miss Nancy Wallace has been appointed to the Border Cities staff. She is a graduate of the school of nursing of Victoria Hospital, London, and of the public health nursing course at the University of Western Ontario.

Miss May Rumney has been transferred from the Toronto Branch to the staff of the Liverpool Branch. Mrs. Thorpes (née Anna MacKenzie) is being temporarily employed by the Liverpool Branch until Miss Rumney reports back for duty.

Miss Mary McIlquham has been transferred from the Dundas Branch to the Border Cities Branch.

Miss Evelyn Logan has been transferred from East York Branch to take charge of the Dundas Branch.

Miss Mary Ross has been transferred from the Cornwall Branch to take charge of the new branch opening in Peterborough.

Miss Jean Hamilton has been appointed to the staff of the Montreal Branch. Miss Hamilton is a graduate of the school of nursing of the Victoria Hospital, London, and of the public health nursing course at the University of Western Ontario.

Miss Rosella Cunningham has been transferred from the Border Cities staff to take charge of the branch in Carleton Place.

Miss Josephine Riley has been transferred from the Winnipeg staff to take charge of the Regina Branch.

Miss Sybil Everitt has resigned as nurse-in-charge of the Moncton Branch to take charge of the Cornwall Branch.

Miss Elsie Dakai has resigned from the Dartmouth staff and has been granted a six month's leave of absence from the Victorian Order of Nurses for Canada.

Miss Jean Leask has resigned as nurse-in-charge of the Regina Branch and from the Victorian Order of Nurses for Canada. Miss Leask was awarded a year's scholarship by the Rockefeller Foundation.

Miss Jean Scrimgeour has resigned from the staff of the North York Branch and has been granted one year's leave of absence from the Victorian Order of Nurses for Canada. Miss Scrimgeour has enlisted in the R.C.A.M.C. as a Nursing Sister.

Miss Isabel Black has resigned from the Victoria staff. Miss Black has accepted a position as health teacher in the Winnipeg General Hospital.

Miss Hilda Morrill has resigned from the staff of the Saint John Branch, and has been granted one year's leave of absence from the Victorian Order of Nurses for Canada. Miss Morrill has enlisted in the R.C.A.M.C. as a Nursing Sister.

Appointment as Acting Inspector

During the absence on military nursing service of Miss Edith Dick, Miss Hilda Bennett will be acting inspector of training schools in the Nurse Registration Branch of the Ontario Department of Health. Born and educated in Ontario, Miss Bennett taught school for three years in the Western Provinces. She received her professional training in the School of Nursing of the University of Alberta Hospital and, after serving as a member of the nursing office staff of the Provincial Hospital in Ponoka,

undertook a year of post-graduate study at the School of Nursing of the University of Toronto. She then entered the Ontario Hospitals Service, and later was appointed superintendent of nurses in the Ontario Hospital, New Toronto.

In announcing Miss Bennett's transfer from one department of the Provincial Nursing Service to another, Miss Munn, director of the nurse registration branch, pays her this tribute : "Miss Bennett has already demonstrated her ability in teaching and in hospital administration and may be depended upon to serve the nursing profession faithfully and well in her new position."

Ontario Public Health Nursing Service

Miss Reba Simpson (Hospital for Sick Children and University of Toronto) has been promoted to the position of supervisor of nursing with the Timmins Board of Health. She succeeds *Miss Lauretta Hall* (now Mrs. H. G. Metcalfe) who resigned in December.

Mrs. Lily Hall (née de Veer), (Toronto General Hospital and C.M.B., England, and public health nursing certificate of the Royal Sanitary Institute, England) has joined the public health nursing staff of the Timmins Board of Health.

Miss Geraldine Mickle (Connaught Training School, Weston, and University of Toronto public health nursing course) has been appointed to the staff of the School of Hygiene, University of Toronto, as a laboratory assistant.

Miss Dorothy Armstrong (Hamilton General Hospital and University of Western Ontario public health nursing course) has succeeded *Miss Hazel Dennis* as public health nurse with the Guelph Public School Board.

Miss Ada Vaughan (Hotel Dieu, Windsor, and University of Western Ontario public health nursing course) has joined the staff of the Windsor Board of Health. This addition to the staff will make possible an extension of the child hygiene service.

Miss Marion Poole has resigned from the staff of the Windsor Public School Health Service.

Miss Hope Linton (University of Toronto School of Nursing undergraduate course) has been appointed to the nursing staff of the East York Board of Health.

Miss Nora Yeo (University of Toronto School of Nursing undergraduate course) has joined the staff of York Township Board of Health, replacing *Mrs. Daisy Cooke* who has resigned.

Miss Leah Culver, Reg. N., formerly of the Fleet Aircraft Company, Fort Erie, has accepted a position with the McKinnon Industries, Ltd., St. Catharines.

Miss Lillian Wark (Metropolitan Life Insurance Company) has been transferred to Sudbury, Ontario. Her position is being filled the beginning of the year by *Miss Willa Ahern*, of Peterborough.

Miss M. Olive Bradley, for many years industrial nurse for the Plymouth Cordage Company of Welland, retired recently, owing to ill health. *Miss Audrey Rice*, of Welland, has been appointed to take her place.

M.L.I.C. Nursing Service

On January 1, 1941, *Miss Alice Girard* (St. Vincent de Paul Hospital, Sherbrooke, 1931, and public health nursing course, University of Toronto School of Nursing) was permanently appointed, and is now on the Montreal staff.

STUDENT NURSES PAGE

A Problem in Health Teaching

M. Bernice Legere *and* Marjorie D. Schryer

Student Nurses

School of Nursing, The Montreal General Hospital

We were nearing the end of our course in health education. What class project could we take up that would give us practice in health teaching as soon as possible after studying that art? Our answer was found in Morris, a baby boy eighteen months old, who had been admitted to our baby ward with a diagnosis of acute tonsillitis and bilateral cervical adenitis. Why was Morris the answer to our question? Because when he first came to our hospital Morris refused to eat, and we decided that by making a study of his past and present health habits we could better understand the problem in health teaching which the nurses had met and overcome. One of the members of our group, who had lately been a student on Ward B and had therefore been able to observe the treatment given, took charge of this project. She was actively assisted by another member of the class in making a study of the case and in presenting the story during one of our class periods.

For several days following admission, Morris had used mealtime as an opportunity to show how many things he could refuse to do. Turning his head as far as possible from side to side, he forcibly got rid of whatever food was placed in his mouth. However, after three weeks in hospital we learned that Morris took his food readily and eagerly waited for each spoonful. How had the change in his behaviour been brought about?

Let us first consider what there is about hospital life which tends to correct faulty habits and to promote heath practices. The children follow a regular routine with regard to eating, sleeping, bathing, and elimination. They get the necessary attention, but not over-attention. Their diet is supervised and they receive proper foods in proper amounts. Their sleep is regulated with special attention to ventilation and quiet. As a result, the children respond desirably to an environment which is physically and emotionally healthful. In teaching Morris, the nurses followed up these advantages by understanding and persistence and by making use of the example set by other children. Underlying his undesirable early behaviour, Morris had a real interest in food, which is a basic human need, and therefore was ready to learn to eat. It was a challenge to his teachers to make sure that he got satisfaction from ways of taking food which were also acceptable to others.

At each mealtime his tray was placed before him and patience and persistence were employed, nurse and pupil both

learning by trial and error. The same situation was repeated frequently, and the occasions were closely associated with other routines, all of which is of value in forming habits. By praising Morris when he dideat a small amount, advances were made. The child attained satisfaction through the comfort of food, through gaining approval, and by imitation of what the other children were doing. Under daily supervision, Morris began to eat everything that was set before him.

Let us turn now to his home environment and try to find out why Morris should have acted so strangely towards food. On visiting the home, we find that the family consisted of mother, father, baby Morris, and Lillian aged four years. They live in a small second-storey flat not far from our hospital. It was a bright cheery little home, very neat and clean. The mother is a healthy-looking young woman about thirty-five years old, very industrious and deeply interested in her children. We learned in our interview with the hospital social worker before visiting the home that the mother would be easy to approach. The social worker also suggested that our visit could be explained on the ground that Morris would soon be ready for discharge and that we wished to prepare his mother for his home-coming. When we explained that we were nurses from the M.G.H. we were immediately welcomed and questioned anxiously about the little boy's condition. Mrs. K. seemed very anxious to have him home. The family is Polish, and Mrs. K. is very skilful at handwork and proudly displayed a cottage set she is designing for her kitchen. This was being done in cross stitch and she said that she and her husband had drawn the design themselves. On seeing that we were interested, she showed us a satin blouse embroidered in bright colours, a beautiful piece of work done by her mother, and worn only on special occasions. Mrs. K. said that her husband was working and told us that she keeps boarders to help meet expenses. Mrs. K. appeared to be a very nervous woman and continually worries about her children. She told us that Morris was a premature baby and that she had always had difficulty in getting him to eat. She admitted that she had had very little patience with him and had never insisted on his taking food. Could this be why he refused to eat when he first came to the hospital? Perhaps, through the home visit, we had stumbled on the real cause of his attitude towards food. His mother thought that enlarged tonsils may have caused difficulty in swallowing, and appeared to use this as an excuse for her lack of firmness. This was natural for a busy woman of her temperament.

Morris is to have a tonsillectomy before going home from the hospital. With the removal of this handicap, and the establishment of good habits we hope that his mother will be encouraged to follow the nurse's instructions regarding persistence and the setting of a good example. In class discussion, one student suggested that it may have been easier to bring about desirable behaviour because of the change to a hospital environment. We agreed that this might be true, and we trustfully leave the supervision of his future welfare with the child welfare nurse in this district.

NEWS NOTES

ALBERTA

PONOKA:

A meeting of District 2, A.A.R.N., was held at the Provincial Mental Hospital, Ponoka, with a large number in attendance. The resignation of Miss C. Nornmansell Jackson, as chairman, was received, and Miss Margaret D. McLean was elected. Miss Helen McArthur gave a stimulating talk on her past year at Columbia University. Dr. R. R. MacLean showed moving pictures taken in England by Dr. Addinell, who is with the R. C. A. M. C.

The officers of the district are now as follows: Chairman, Miss Margaret D. McLean; vice-chairman, Miss Edith Mills; secretary-treasurer, Miss Edith D. Kemp.

VEGREVILLE:

Vegreville General Hospital:

The following officers have recently been elected to serve during the coming year by the Alumnae Association of the Vegreville General Hospital: Honourary president, Rev. Sister Anna Keohane; honourary vice-president, Rev. Sister Josephine Boisseau; president, Mrs. H. Walker; vice-president, Mrs. D. Triska; secretary-treasurer, Miss Annie Askin; archivist, Rev. Sister Cecilia Clermont.

BRITISH COLUMBIA

VANCOUVER:

The University of British Columbia Nursing Club held a very successful tea recently at which the annual report was given and election of new officers was held.

Married: Recently, Miss Shirley Marguerite Sager (V.G.H., 1935) to Mr. Jack M. Morrison.

Married: Recently, Miss Helen Winnifred Connor (V.G.H.) to Mr. Logan Melville Findlay.

Married: Recently, Miss Velma Aileen Bastedo (St. Joseph's Hospital, 1937) to Mr. H. J. Hennings.

Married: Recently, Miss Ruth Cheeseman (V.G.H. and U. of B.C., 1934) to Mr. Lloyd E. Short.

Married: Recently, Miss Sereta Annetta Hutton (V.G.H., 1937) to Rifleman Harley Kenzie Davidson.

Married: Recently, Miss Margaret Hay (V.G.H.) to Mr. Ronald Makepeace.

NELSON:

The following officers have recently been elected to serve during the coming year by the Nelson Registered Nurses Association: Honourary president, Miss V. B. Eidt; president, Miss H. Tompkins; first vice-president, Miss Ethel Smith; second vice-president, Miss V. Hayden; secretary, Miss A. McKinnon; treasurer, Miss Elsie M. Smith; committee conveners: private duty, Miss J. McVicar; membership, Miss E. Abey; ways & means, Miss L. Ellis; social, Miss G. Gowans; program, Miss I. Mack; visiting, Miss P. Gansner; representative to *The Canadian Nurse*, Miss N. Murphy.

MANITOBA

WINNIPEG:

Winnipeg General Hospital:

Miss Mabel Lyons and Miss Frances Anderson have recently enlisted for military nursing service. Miss A. Dickson (W.G.H., 1936) has recently accepted a staff position in the Winnipeg General Hospital.

Married: Recently, Miss Dorothy Rose (W.G.H., 1937) to Mr. Gordon Sutherland.

Married: Recently, Miss Doreen Alexander (W.G.H., 1937) to Mr. George Baker.

Married: Recently, Miss Alma O'Neil (W.G.H., 1938) to Mr. Harris.

Married: Recently, Miss Dorene McGuinness (W.G.H., 1936) to Dr. Robert Inglis.

Married: Recently, Miss Mary Greaves (W.G.H., 1939) to Lieut. Robert Tucker R.C.A.M.C.

NEW BRUNSWICK

MONCTON:

The regular monthly meeting of the Moncton Chapter, N.B.A.R.N., was held recently with the president, Miss Hillyard, in the chair. Routine business was transacted. The treasurer's report showed a profit of $249. from a dance and a lottery on a hope chest and its contents, held under the sponsorship of Miss Anna Horseman and Miss Roberta Gunn.

Miss Everitt, a valued member of the Association, and of the staff of the V.O.N., has recently been transferred to Cornwall, Ontario, to further her duties in that area. We are very sorry to lose her.

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Peterborough, Ontario.

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Married: Recently, Miss Dorothy Smith to Mr. Clarence Tingley.

Married: Recently, Miss Anna Horseman to Mr. L. Steeves.

NOVA SCOTIA

All hospital schools for nurses, and the registered nurses in the different branches, are unusually active this year. Most of the hospital and school staffs have suffered severe losses in that their doctors and nurses have been called for active service. The spirit revealed by those left to carry on, many with double work to do, is one we may all be proud of. Preparedness seems to be the ideal. The registered nurses deserve special mention for the excellent work they are doing with respect to the refresher courses. They are preparing themselves so that we may have more qualified instructors to teach and supervise the courses given in co-operation with the St. John Ambulance Association.

Practically all the instructors are using the "Supplement" and find it a priceless addition to the Proposed Curriculum. The guidance pamphlets have been distributed, and we hope to hear from the colleges and high schools regarding their value. The instructors have added to their school studies the St. John Ambulance Courses. Some schools are also giving a course in adult education. The cultural and social life of the nurse will be well taken care of; the personnel is studied and public relations are explained. Attractive and interesting programs are planned, so that the dramatic ability and musical talents of the students are developed. Presenting tableaux, pageants, or dramatizing scenes that take place in hospital life are encouraged.

Cape Breton:

The Cape Breton instructors' group report that in addition to the regular monthly meetings of the registered nurses, four special meetings for the instructors have been planned. The first of these was held at the City of Sydney Hospital. Nearly all the schools were represented, and two guest instructors from St. Martha's Hospital School for Nurses also attended. Sister Mary Peter was named president, and Miss F. MacDonald secretary of the instructors' group. The first work was to arrange a program for the remaining meetings which will be held the last Tuesday in March and May in the City of Sydney Hospital. The importance of ward supervision, and of spending as much time as possible in the wards with the preliminary students, was explained by the different instructors. Miss Rhoda MacDonald told us how she linked her classes in hygiene with her health program. The students weigh themselves, and report on their own X-rays of chest and laboratory examinations. The findings are recorded on a special health card which is examined monthly by the director of nurses. All were greatly impressed by this idea of the students applying their hygiene classes in their daily lives. This is an excellent way to teach students to take responsibility. Notes were exchanged on case study methods, and the forms used by the different schools. All the instructors mentioned that the most serious weakness, noted in the education of the preliminary students, is their lack of knowledge of mathematics. What can be done? All are high school graduates. At this point it was asked if some form of test could be given to all applicants.

Psychological tests were discussed, as were intelligence, personality, and aptitude tests, as a means of obtaining objective information regarding the suitability of the candidate. All were of the opinion that in evaluating the capacities of the individual the result of any one test should not be treated singly but in relation to all other tests which are being applied at the same time. No schools in Cape Breton at present are using these tests. Disciplinary policy was discussed, and it was recommended that records of all corrections should be kept. Cultural and social development, in the life of the nurse, was held to be an important part of the curriculum. Methods used by the instructors

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as aids to developing the cultural and social life of the students include libraries, "capping" programs, social evenings, and debates.

HALIFAX:

The first meeting of the Halifax Instructors Group was held recently at the Halifax Infirmary. The following were present: Miss M. K. Miller, Miss H. Joncas, Miss. E. Hugel, Miss J. MacCann, Miss A. Archer, Miss L. Grady, Miss A. McKay, Sister Camillus de Lellis, and Sister Mary Peter. Many topics were discussed, including the "Supplement", which is such an ideal addition to the Proposed Curriculum. The value of staff conferences in keeping the supervisors interested in their all important duty as assistant instructors was explained. The "Supplement", and "The Hospital Head Nurse" by Mary Wayland will furnish priceless material for staff conferences. Copies of Miss A. J. Macleod's report, "Nursing and Nurse Education in Canadian Hospitals", were given to the instructors for study. Special study will be given to the school records, as requested by the Canadian Nurses Association. The following officers were appointed: president, Miss H. Joncas; secretary, Miss M. K. Miller. The group plans to meet the third Tuesday in March and May at the Victoria General Hospital.

NEW GLASGOW:

Aberdeen Hospital:

The Alumnae Association of the School of Nursing of the Aberdeen Hospital held their monthly meeting recently at the nurses' residence. A very interesting series of lantern slides on the history of nursing in Canada was shown to the members by Miss Mary I. Crossman, superintendent of the hospital.

Married: Recently, Miss Emily Theresa Marshe (A. H., 1939) to Mr. Kenneth Robert MacDonald.

ONTARIO

A cheque for $9,600. was recently presented to the Canadian Red Cross Society on behalf of the nurses of Ontario. Presentation was made by Miss Mary Sunley, convener of the Ontario Nurses' War Fund Committee, and Miss Matilda E. Fitzgerald, treasurer of the Fund. The money has been designated for emergency surgical units, each costing about $1,000., to be placed on

east and west Canadian coasts for war relief. The mobile units are the type which can be used in out-post hospitals after the war.

District 1

Chatham:

St. Joseph's Hospital:

The following officers have recently been elected to serve during the coming year by the Alumnae Association of St. Joseph's Hospital: Honourary president, Mother M. Pascal; honourary vice-president, Sister M. Thecla; president, Miss Mary Doyle; first vice-president, Miss Hazel Gray; second vice-president, Miss Evelyn Cadotte; secretary-treasurer, Miss May Boyle; corresponding secretary, Miss Anne Kenny; representative to *The Canadian Nurse,* Miss Mary Clare Zink.

Districts 2 and 3

Kitchener:

The following officers have recently been elected to serve during the coming year by the Alumnae Association of the Kitchener and Waterloo General Hospital: Honourary president, Miss K. W. Scott; president, Miss Thelma Sittler; first vice-president, Mrs. J. Collins; second vice-president, Miss R. Bagshaw; secretary, Miss Velma Eveleigh; treasurer, Miss E. Janzen; committee conveners: program, Miss H. Murdock; flowers: Miss M. McManus, Miss M. McLean; social, Mrs. J. Collins; representative to *The Canadian Nurse,* Miss Anne Leslie.

The Alumnae Association of the Kitchener and Waterloo General Hospital held a very enjoyable Christmas party with about forty members present. The members of the graduating class of 1941 were the special guests for the evening.

Miss Frances Marion Oakes (K.W.H.) was recently appointed to the staff of a military hospital at St. Thomas.

Married: Recently, Miss Hazel Adair (K.W.H.) to Mr. Russell Ellacott:

Married: Recently, Miss Marjorie Johnson (K.W.H., 1940) to Mr. Robert Ritchie.

Married: Recently, Miss Olive Hughes (K.W.H., 1940) to Mr. Orville Hardy.

Married: Recently, Miss Fosta Marches (K.W.H., 1937) to Mr. Geo. Doubt.

Married: Recently, Miss Magdalene Wilkinson (K.W.H., 1936) to Dr. A. B. Sinclair.

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STRATFORD:

Stratford General Hospital:

The following officers have recently been elected to serve during the coming year by the Alumnae Association of the Stratford General Hospital: Honourary president, Miss A. M. Munn; president, Miss Murdean Mackenzie; vice-president, Miss Bessie Williams; secretary-treasurer, Miss Jean Bell; committee conveners: social, Miss Alice Bailey; flowers and gifts, Miss Mae Cardwell.

DISTRICT 5

TORONTO:

Toronto Western Hospital:

The annual meeting of the Toronto Western Hospital Alumnae Association was held recently with the vice-president, Mrs. Chant, in the chair. There were reports from the standing committees and election of new officers. The treasurer reported that there had been total receipts of $1229.10 with total disbursements of $938.74. It was very gratifying to know that since last March the Red Cross Auxiliary of the Alumnae Association had raised $1514.13 and had disbursed $574.13, leaving a balance of $940. on hand. This was in addition to many surgical dressings made and delivered for sterilization, knitted articles, and quantities of refugee clothing and quilts made by the sewing division. The Alumnae Association is also supporting a graduate of the school at the University of Toronto, Public Health Division.

A pleasant musicale had been arranged by the program committee to follow the business meeting, and a social hour followed.

The officers for the year 1941 are as follows: Honourary presidents, Miss B. Ellis, Mrs. C. J. Currie; president, Mrs. Douglas Chant; vice-president, Miss Mae Palk; corresponding secretary, Miss Isabel Kee; recording secretary, Miss Margaret Elliot; treasurer, Miss Benita Post; representative to *The Canadian Nurse*, Miss Jessie Wallace.

Married: Recently, Miss Jean McFadden (T.W.H., 1938) to Mr. Gibson.

Married: Recently, Miss Margaret McColl (T.W.H., 1938) to Dr. Burke.

Married: Recently, Miss Margaret Wright (T.W.H., 1938) to Mr. Doherty.

Married: Recently, Miss Inez Butler (T.W.H., 1938) to Dr. Bruce Vale.

Married: Recently, Miss Gertrude Finch (T.W.H., 1934) to Mr. Keenan.

Married: Recently, Miss Alice Milliken (T.W.H., 1938) to Mr. Herbert.

Women's College Hospital:

The following officers have recently been elected to serve during the coming year by

the Alumnae Association of the Women's College Hospital, Toronto: Honourary president, Mrs. Bowman; honourary vice-president, Miss H. T. Meiklejohn; president, Mrs. S. Hall; recording secretary, Miss Isabel Hall; treasurer, Miss W. Worth; representative to *The Canadian Nurse*, Miss Mary Chalk.

District 6

Port Hope:

The annual meeting of District 6, R. N. A. O., was held recently at the public library, with the chairman, Miss H. Collier, presiding. There was a large attendance and lively discussion during the business meeting. The speaker of the evening, Mrs. Norman Taylor of Port Hope, chose for her address the subject of amateur photography as a hobby, and illustrated her talk with several coloured transparencies. At the close of the meeting, Miss E. Elliot, superintendent of Port Hope General Hospital, and staff entertained for a social hour at the nurses residence. The officers and conveners for the coming year were elected as follows: Chairman, Miss I. Shaw, Cobourg; first vice-chairman, Miss M. McKenzie, Lindsay; second vice-chairman, Miss E. Covert, Cobourg; third vice-chairman, Miss E. Wright, Belleville; secretary-treasurer, Miss V. Taylor, Cobourg; conveners of committees: nurse education, Miss Young, Peterborough; private duty, Miss N. DiCola, Belleville; public health, Miss L. Stewart, Peterborough; membership, Miss N. Brown, Belleville; enrolment, Miss H. Fitzgerald, Belleville; finance, Miss F. Fitzgerald, Belleville; nomination, Miss M. Robinson, Cobourg. Miss M. Gibb, Port Hope General Hospital, recently attended the refresher course on hospital administration given by the Toronto University School of Nursing.

Cobourg:

The annual meeting of Chapter B., District 6, R. N. A. O., was held recently at Cobourg General Hospital. The question of associate membership was discussed. A committee was appointed to interview the non-active nurses stating our plans and were asked to give a report at the next meeting. The suggestions from the committee on Emergency Nursing Service were dealt with in detail. It was decided that Port Hope and Cobourg would organize their classes separately and would endeavour to begin early in 1941. The officers for the coming year were elected as follows: Chairman, Mrs. R. Beatty; vice-chairman, Miss E. Covert;

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secretary-treasurer, Miss O. Moore; conveners of committees: nurse education, Miss E. Elliott; private duty, Miss E. Shepherd; public health, Miss M. Polson; nomination, Miss V. Sawyer; membership, Miss M. Waechter; social, Miss Baker; program, Miss J. Graham; *The Canadian Nurse*, Miss E. Evans.

Miss R. Arksey, Soldiers' Memorial Hospital, Orillia; Miss J. Johnstone, Oshawa General Hospital; and Miss M. Doyle, Hotel Dieu Hospital, Kingston, have recently joined the staff of the Ontario Hospital, Cobourg.

LINDSAY:

Ross Memorial Hospital:

A delightful tea and sale of home-made cooking was recently held by the Alumnae Association of the Ross Memorial Hospital at the home of Mrs. J. S. Mackey. Miss E. Reid, superintendent of Ross Memorial Hospital, and Miss F. Moffat, president of the Alumnae Association, together with the hostess, received the guests. Miss Madalene Baker of London, Ontario, addressed a special meeting of the nurses on "Eight-Hour Duty". This system of a shorter day for nurses was enforced in November in the Ross Memorial Hospital by the graduate nurses. With the assistance given by Miss Baker, committees were chosen which resulted in the establishment of a Nurses Registry in Lindsay on December 1.

At a recent meeting of the Alumnae Association of the Ross Memorial Hospital excellent reports were submitted by Miss A. Flett, convener of Red Cross supply, and Mrs. R. Rutherford as treasurer. A brief report of the arrangements made by the committee in charge of the new registry for nurses was given by Miss L. Gillespie. The Alumnae sponsored a theatre night in the collegiate auditorium when the comedy play "The Curtain Rises", highly recommended by Mr. Quarrington, was presented. The election of officers for the coming year took place and resulted as follows: Honourary president, Miss E. S. Reid; president, Miss Flora Moffat; first vice-president, Mrs. M. Thurston; second vice-president, Miss Gladys Lehigh; secretary, Miss Doris Currins; treasurer, Mrs. Ursula Cresswell; program committee: Miss Lenore Harding, Miss Dorothy Wilson; refreshment committee: Miss Pauline Kirley, Miss M. Stewart; flower committee, Miss Alma Irvine; press secretary, Miss Ethel Lowe; Red Cross supply, Miss Aileen Flett. At the close of the meeting a social hour was enjoyed.

Married: Recently, Miss Margaret Jean McEachern (R. M. H., 1939) to Mr. Robert James Gordon.

Married: Recently, Miss Maude Gordon (R.M.H., 1938) to Pte. Bertram Cliff.

Married: Recently, Miss Audrey Isobel Hickson (R.M.H., 1934) to Mr. William Ralph Rodman.

District 7

Brockville:

Brockville General Hospital:

A meeting of the Alumnae Association of the Brockville General Hospital was held recently for the reception of annual reports of the various committees. The past year has proved to be a particularly active year for the society. In June a very successful program was carried out for the reunion of graduates, celebrating the fiftieth anniversary of the Training School. Members have been very active in Red Cross work, making surgical and hospital supplies and doing considerable knitting. In July $114.15 was raised by voluntary subscription for the Ontario Nurses' War Fund. The Association also maintains a private room in the hospital.

The report of the nomination committee, presented by Miss Viola Allan, was adopted and officers for 1941 are as follows: Honourary presidents, Miss Alice L. Shannette, Miss Edith Moffatt; president, Mrs. Mae White; first vice-president, Mrs. Wm. Cooke; second vice-president, Miss Lucy Merkley; secretary, Miss Helen Corbett; assistant secretary, Mrs. Earle Finlay; treasurer, Mrs. H. Vandusen; committee conveners: flower, Miss Violet Kendrick; social: Mrs. H. Green, Miss Marjorie Gardiner; program: Mrs. M. Derry, Miss Viola Allan; property: Mrs. M. Derry, Miss. J. McLaughlin; annual fees, Miss M. Donald; representative to the Brockville Branch of Red Cross Society, Mrs. H. Green; representative to *The Canadian Nurse*, Miss Helen Corbett.

Married: Recently, Miss Phyllis (B.G.H., 1939) to Mr. Oswald Law.

Married: Recently, Miss Iva Comerford to Mr. George Boyle.

Kingston:

Kingston General Hospital:

Miss Mabel Bonter, who has been sixteen years at the K.G.H., recently resigned her position owing to ill health, and will reside at her home in Trenton.

The following officers have recently been elected to serve during the coming year by the Alumnae Association of the Kingston General Hospital: Honourary president, Miss L. Acton; president, Mrs. F. Atack;

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Married: Recently, Miss Norma R. Shumway (K.G.H., 1936) to Lieut. Joseph F. A. McManus, R.C.A.M.C.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

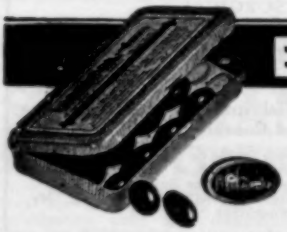
Miss Sylvia Fisk (C.M.H., 1933) and Miss Gertrude Layman (C.M.H., 1933) have been appointed to the staff of the No. 1 Canadian General Hospital, R.C.A.M.C., and are now in England.

Montreal General Hospital:

At the December meeting of the Alumnae Association of the Montreal General Hospital, Dr. Guy Fisk gave a very interesting illustrated lecture on the advances made in treatments of disease by physical therapy, and the precautions to be taken by the persons administering such treatment.

The usual Christmas festivities were held at the hospital, starting by the singing of carols in wards on Christmas morning. The Governors' dance for the graduate staff was held on December 27, and the party for the children of employees took place on December 28. Miss Holt and staff were "at home" on New Year's Day and were pleased to welcome many of the former graduates and friends.

Miss Dorothy Darby (M.G.H., 1938) has accepted a position as industrial nurse in a large munition plant which is now under construction.



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Married : Recently, Miss Louise Farmer (M.G.H., 1940) to Dr. Charles E. Decker.

Royal Victoria Hospital :

Miss Alice Crickard, who has been assistant on the second floor of the Ross Pavilion, is now in charge of the Men's Medical Ward A, Miss Erma Murray replacing Miss Crickard on the second floor. Miss Winnifred MacLeod is now in charge of the ear, nose, and throat ward, replacing Miss Rhoda Stewart who has resigned. Miss Gertrude Yeats has been appointed instructor in obstetrics and gynaecology.

Miss Muriel Moar, who has been doing general duty, is now on the staff of the outdoor department, replacing Miss Kathleen DeWitt who has resigned.

Miss Jean McKenzie is now in charge of the Men's Surgical Ward G, replacing Miss Elma Hamilton who resigned to be married.

Miss Ebba Neilsen, who has been in charge of the fifth floor, Ross Pavilion, has resigned to be married, and Miss Hilda Sargent is now in charge.

Married : Recently, Miss Helen Irene Flewelling (R. V. H., 1939) to Mr. Edward Arthur Wilson.

School for Graduate Nurses, McGill University :

Miss Dorothy King and Miss Frances Copeman (Teaching & Supervision, 1937-38) are now Nursing Sisters with the R. C. A. M. C. in Saskatchewan.

Married : Recently, Miss Marian Christabelle Clark (Teaching & Supervision, 1937-38) to Surgeon Lieut. Timothy Blair MacLean.

NEWFOUNDLAND

St. John's :

Due to the prevailing epidemic of influenza, the Newfoundland Graduate Nurses were forced to postpone their December meeting. However, the next meeting is to be a very special one when an exhibit loaned by *The Canadian Nurse* will be shown. This exhibit was prepared by The Canadian Nurse Committee of the Association of Registered Nurses of the Province of Quebec and one item, an especially attractive one, shows a replica of the rheumatism pavilion of the Children's Memorial Hospital in Montreal. Another shows nurses arriving at a convention; and the third shows "Nursing History, East and West." We are also hoping to have Miss Marjorie News, M.A., Assistant Librarian, speak to us on books.

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District 6

Chairman, Miss I. Shaw; First Vice-Chairman, Miss M. McKenzie; Sec. Vice-Chairman, Miss Covert; Sec.-Treas., Miss V. Taylor, General Hospital, Cobourg; *Committee Conveners*: *Hospital & School of Nursing*, Miss E. Young; *General Nursing*, Miss N. DiCola; *Public Health*, Miss Stewart; *Membership*, Miss N. Brown; *Enrolment*, Miss H. Fitzgerald; *Finance*, Miss F. Fitzgerald.

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Prince Edward Island Registered Nurses Association

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QUEBEC

Association of Registered Nurses of the Province of Quebec (Incorporated, 1920)

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Saskatchewan Registered Nurses Association (Incorporated, 1917)

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Regina Registered Nurses Association

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Alumnae Associations

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A.A., Vegreville General Hospital, Vegreville

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BRITISH COLUMBIA

A.A., St. Paul's Hospital, Vancouver

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A.A., Vancouver General Hospital, Vancouver

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A.A., Children's Hospital, Winnipeg

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A.A., Saint John General Hospital, Saint John

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A.A., L. P. Fisher Memorial Hospital, Woodstock

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A.A., Victoria General Hospital, Halifax

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ONTARIO

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A.A., Brockville General Hospital, Brockville

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